National Library of Canada
Canadian Theses Service
Ottawa, Canada
K1A 0N4

Bibliothèque nationale du Canada
Service des thèses canadiennes

NOTICE

The quality of this microform is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us an inferior photocopy.

Previously copyrighted materials (journal articles, published tests, etc.) are not filmed.

Reproduction in full or in part of this microform is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30.

AVIS

La qualité de cette microforme dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de qualité inférieure.

Les documents qui font déjà l'objet d'un droit d'auteur (articles de revue, tests publiés, etc.) ne sont pas microfilmés.

La reproduction, même partielle, de cette microforme est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30.

NL-339 (r. 86/04)

Canada

THE UNIVERSITY OF ALBERTA

GROUP REMINISCENCE THERAPY AS A NURSING INTERVENTION: AN EXPERIMENTAL STUDY

BY

© ANN TOURANGEAU

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH
IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF THE DEGREE
OF MASTER OF NURSING

FACULTY OF NURSING

EDMONTON, ALBERTA

FALL, 1988

Permission has been granted to the National Library of Canada to microfilm this thesis and to lend or sell copies of the film.

The author (copyright owner) has reserved other publication rights, and neither the thesis nor extensive extracts from it may be printed or otherwise reproduced without his/her written permission.

L'autorisation a été accordée à la Bibliothèque nationale du Canada de microfilmer cette thèse et de prêter ou de vendre des exemplaires du film.

L'auteur (titulaire du droit d'auteur) se réserve les autres droits de publication; ni la thèse ni de longs extraits de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation écrite.

ISBN 0-315-45590-X

THE UNIVERSITY OF ALBERTA

RELEASE FORM

NAME OF AUTHOR: ANN TOURANGEAU

TITLE OF THESIS: GROUP REMINISCENCE THERAPY AS A NURSING INTERVENTION: AN EXPERIMENTAL STUDY

DEGREE: MASTER OF NURSING

YEAR THIS DEGREE GRANTED: 1988

Permission is hereby granted to THE UNIVERSITY OF ALBERTA LIBRARY to reproduce single copies of this thesis and to lend or sell such copies for private, scholarly or scientific research purposes only.

The author reserves other publication rights, and neither the thesis nor extensive extracts from it may be printed or otherwise reproduced without the author's written permission.

Signed: Ann Tourangeau

PERMANENT ADDRESS:

1509, 8210 - 111 Street
Edmonton, Alberta
T6G 2C7

Date: June 8, 1988

THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled GROUP REMINISCENCE THERAPY AS A NURSING INTERVENTION: AN EXPERIMENTAL STUDY submitted by ANN TOURANGEAU in partial fulfilment of the requirements for the degree of MASTER OF NURSING.

Supervisor

Date: June 8, 1988

DEDICATION

To my family, especially Kathie, for their support and encouragement.

To Fil and Ron Nalewajek, for their support and encouragement.

To Joy Tough, for her invaluable assistance in leading the current events discussion groups.

To Dawn Friesen, for her friendship and support.

To friends, who have listened and supported so patiently.

And especially to those patients who participated in this study, for their willingness to share and to help others.

ABSTRACT

The purpose of this study was to investigate the effects of group reminiscence therapy on the levels of depression and self-esteem in elderly patients. It has been suggested that group reminiscence therapy might assist elderly people to engage in the process of life review. Through reminiscing, the elderly person would work toward resolving what theorists have described as the developmental crisis of the last stage of the lifecycle, that of ego integrity versus despair.

An experimental design, incorporating the three treatment conditions of group reminiscence therapy, current events discussion group, and no intervention, were used. After providing informed consent, the non-probability sample, consisting of 37 elderly patients who lived in an extended care center in Western Canada, was randomly assigned to one of the three treatment groups. All subjects were tested before the treatment (pre-test) and again after the treatment period (post-test) on the dependent variables of depression (measured by the Geriatric Depression Scale) and self-esteem (measured by the Rosenberg Self-Esteem Scale). The reminiscence and current events group met once weekly for a period of eight weeks.

It was hypothesized that the elderly who participated in group reminiscence therapy would demonstrate significantly greater decreases in depression and significantly greater increases in self-esteem than participants in both of the other treatment

conditions. The findings of this study supported the hypotheses. Reminiscence group subjects demonstrated a significant mean decrease in levels of depression and a significant mean increase in levels of self-esteem. Subjects in the other two treatment groups did not demonstrate any significant changes in levels of depression and self-esteem. These findings suggested that group reminiscence therapy was an effective nursing intervention which promoted increased self-esteem and decreased depression in elderly patients.

ACKNOWLEDGEMENTS

I wish to acknowledge a number of persons and organizations who have assisted in the completion of this study. First, I would like to express my sincere gratitude to the members of my thesis committee. I would like to thank Dr. Janet Kerr, my thesis chairperson, for her assistance, encouragement, and consistent expressions of faith in me. I would like to thank Professor Olive Yonge for the continuous support and encouragement she has provided me. I would like to thank Dr. Steve Hunka for his enthusiasm and willingness to assist, especially with the data analysis.

Second, I would like to express my gratitude to Joyce Johnson for her enthusiasm and assistance. With her support and faith in the project, the investigation progressed smoothly from the beginning to the end.

Third, I wish to thank John Lung for his assistance in preparing the figures used in the thesis.

Fourth, I wish to thank Trish Kryzanowski for her secretarial assistance in formatting the document. Through her flexibility and patience, the thesis was prepared and printed.

And finally, I wish to express my gratitude to the Alberta Foundation for Nursing Research for the student grant support they provided to assist in the completion of this project.

TABLE OF CONTENTS

CHAPTER		PAGE
I.	INTRODUCTION AND STATEMENT OF THE PROBLEM	1
	General Problem	1
	Conceptual Framework	2
	Specific Problem	4
	Purpose of the Study	4
	The Research Question	5
	Definition of Terms	5
	Assumptions	7
II.	REVIEW OF THE RELATED LITERATURE	8
	Introduction	8
	Definition of Reminiscence and its Relation to Life Review	8
	Purpose of Reminiscence	9
	Reminiscence Therapy	12
	Purposes and Benefits of Reminiscence Therapy	13
	Potential Negative Effects of Reminiscence Therapy	19
	Conditions Needed to Carry Out Group Reminiscence Therapy	20
	Summary	23

CHAPTER PAGE

III. METHOD AND PROCEDURES 25

Design 25

Setting 27

Population, Sample, Sampling 30

Instruments 36

Mental Status Questionnaire 37

Rosenberg Self-Esteem Scale 38

Geriatric Depression Scale 40

Procedure 41

Group Treatments 46

Current Events Discussion 46

Group Reminiscence 47

Ethical Considerations 48

Data Analysis 51

IV. RESULTS, DISCUSSION & INTERPRETATION 53

Introduction 53

Depression 55

Descriptive Statistical Results 55

ANOVA Results 60

Contrasts of Specific Means 62

Additional Analyses Using ANOVA 66

CHAPTER PAGE

Self-Esteem 68

Descriptive Statistical Results 68

ANOVA Results 73

Contrasts of Specific Means 76

Additional Analyses Using ANOVA 79

Summary of the Results 80

Interpretation of the Findings 82

V. CONCLUSIONS AND RECOMMENDATIONS 88

Conclusions 88

Limitations of the Study 89

Implications for Nursing 90

Recommendations for Study 92

Summary 93

REFERENCES 96

APPENDIX A 104

APPENDIX B 105

APPENDIX C 106

APPENDIX D 107

APPENDIX E 109

LIST OF TABLES

Table	Description	Page
3.1	Study Design	28
3.2	Summary of Personal Variables	33
4.1	DEPRESSION: Descriptive Results	56
4.2	DEPRESSION: Mean Group Scores	57
4.3	DEPRESSION: ANOVA Results	61
4.4	DEPRESSION: Contrasts/Multiple Comparisons	63
4.5	DEPRESSION: Additional ANOVA Results	67
4.6	SELF-ESTEEM: Descriptive Results	69
4.7	SELF-ESTEEM: Mean Group Scores	70
4.8	SELF-ESTEEM: ANOVA Results	75
4.9	SELF-ESTEEM: Contrasts/Multiple Comparisons	77
4.10	SELF-ESTEEM: Additional ANOVA Results	81

LIST OF FIGURES

Figure	Description	Page
1.	Group mean depression scores (pre-test to post-test) ..	58
2.	Group mean self-esteem scores (pre-test to post-test)..	71

CHAPTER ONE

INTRODUCTION AND STATEMENT OF THE PROBLEM

General Problem

Elderly persons in present day western society frequently experience feelings of low self-esteem and depression. It has been suggested that such feelings commonly found in elderly persons, are associated with the multiple changes with which the elderly are confronted. Many of these changes are perceived and experienced by the elderly as losses. To name just a few, elderly persons lose significant others, physical health, work roles, independence, a valued position in society, and they also experience the impending loss of life (Lewis, 1971; Parsons, 1986; Whalen, 1980; Whall, 1987). Because nurses provide nursing care for elderly patients, they have the opportunity and the responsibility to plan and implement nursing interventions which promote increased self-esteem and decreased depression in their elderly patients.

Presently in the discipline of nursing, considerable effort is being expended to structure nursing knowledge in an attempt to define the unique role and domain of nursing. Nurses are formulating standard diagnostic categories (nursing diagnoses) which reflect patient problems within the domain of nursing. The objective is to structure nursing knowledge so that for each standard nursing diagnosis or patient problem identified, a list of potential nursing interventions would be devised which could be implemented to deal effectively with that patient problem

(Carpenito, 1987). Through nursing research, the effectiveness of suggested nursing interventions for dealing with each nursing diagnosis should be tested. Nurses would then be able to make more informed choices as to which nursing interventions would be most effective for the specified patient problem. This evidence would expand the body of nursing knowledge related to nursing interventions.

Conceptual Framework

The conceptual framework guiding this study encompassed two theories: Erikson's theory of the psychosocial stages of development (Erikson, 1963) and Butler's theory of life review (Butler, 1963, 1974). According to Erikson, personality develops over the entire lifecycle through a process of interaction between the person and society. The lifecycle consists of eight major stages of development. Within each stage of development, the person faces a unique developmental conflict or crisis. Each crisis has a critical time period within the lifecycle when it overshadows other conflicts. To resolve this conflict, the person works on specific developmental tasks associated with that stage. According to Erikson, the conflict in each stage should be satisfactorily resolved so that successful resolution of conflicts in the later stages of the lifecycle can occur.

In the final stage of the lifecycle, the older adult faces the crisis of ego integrity versus despair. In this stage, the older adult is faced with the tasks of evaluating the life experiences, and finding order and meaning in life. With successful resolution

of the tasks of this stage, the older adult experiences feelings of integrity and acceptance about the life lived. Unsuccessful resolution of the tasks of this stage results in the older adult experiencing feelings of despair about the life lived.

Butler's concept of life review (1963, 1974) suggested that life review is an important and universal process in which the older person attempts to work through the developmental crises of late adulthood. The life review process is characterized by a progressive return to consciousness of past experiences significant for that person. These past experiences often, but not necessarily always, involve themes of unresolved conflicts from earlier times in life. Life review usually contains an evaluative component rather than being a simple recall of a past experience. The person attempts to evaluate the experience to make meaning or sense of it. Butler claimed that the process of life review is not limited to the elderly, but that it does become intensified in that period of life (Lewis & Butler, 1974). Through life review, the elderly person attempts to evaluate life experiences to find meaning and order in the life lived. The process of life review involves reminiscing - either silently to oneself (solitary) or by sharing these reminiscences with others (interactive) (Butler, 1963, 1974; Lewis, 1971). Successful resolution of the conflict of ego integrity versus despair in the final stage of the lifecycle can be facilitated through the process of life review by reminiscing.

Specific Problem

Reminiscence therapy is one nursing intervention discussed in the literature as promoting increased self-esteem and decreased depression in elderly patients (Beaton, 1980; Butler, 1974, 1975; Ebersole & Hess, 1985; Hala, 1975; Hamilton, 1985; Matteson & Munsat, 1982; Parsons, 1986; Poulton & Strassberg, 1986; Schnase, 1982; Whalen, 1980). Elderly persons are frequently confronted with a number of losses. The perceptions of these losses may act as stimuli promoting feelings of decreased self-worth and of increased sadness and despair. Through reminiscing or engaging in the process of life review, the elderly person is assisted to find meaning of the life lived and to balance the contrast between their present situation of losses and diminished capacity with a past in which the person was competent and beloved (MacRae, 1982), thus promoting feelings of increased self-esteem and decreased depression. More empirical evidence is needed to establish the effectiveness of reminiscence therapy as a nursing intervention which promotes self-esteem and decreases depression in elderly patients. This empirical evidence can help nurses make more informed choices of nursing interventions to help elderly patients experience increased feelings of self-esteem and decreased feelings of depression.

Purpose of the Study

The purpose of this study was to increase the body of nursing knowledge by investigating the effects of group reminiscence therapy on the levels of self-esteem and depression in a group of

elderly patients. An experimental group receiving group reminiscence therapy and two control groups, with different experimental conditions, were incorporated in the study (a current events discussion group and a no intervention group). These two control groups were used in this study so that comparisons could be made among groups about the effects of each group treatment on the variables of self-esteem and depression.

The Research Question

The research question in this study was: what are the effects of group reminiscence therapy on the levels of self-esteem and depression of elderly patients?

Hypotheses

The hypotheses tested were:

1. elderly patients receiving group reminiscence therapy will demonstrate significantly greater decreases in depression (after the treatment period) than participants in both of the other treatment conditions; and,
2. elderly patients receiving group reminiscence therapy will demonstrate significantly greater increases in self-esteem (after the treatment period) than participants in both of the other treatment conditions.

Definition of Terms

Elderly Patient: An elderly patient is a patient who is at least sixty years of age and who resides in an extended care facility.

Reminiscence: Reminiscence is the retrospection and recall of events which occurred in the past.

Life Review: Life review is a natural process in which the elderly person recalls or reminisces about past experiences that are significant. The person not only recalls the past experience but evaluates the reminiscence in order to find meaning for the experience.

Group Reminiscence Therapy: Group reminiscence therapy is a treatment condition in which elderly patients are helped to engage in the life review process. A nurse-therapist encourages and guides a group of elderly patients to reminisce and engage in interactions and evaluations about these reminiscences.

Current Events Discussion: Current events discussion is a treatment condition in which a nurse-therapist encourages and guides a group of elderly patients to discuss current events.

Self-Esteem: Self-esteem is the individual's perception or judgement of his or her own self-worth (Roy, 1984; Stuart & Sundeen, 1983). In this study, self-esteem was measured as the value the subject scores on the Rosenberg Self-Esteem Scale (Rosenberg, 1965).

Depression: Depression is a mood disturbance characterized by feelings of sadness, despair, and discouragement resulting from and proportionate to the perception of some personal loss or tragedy (Mosby's medical & nursing dictionary, 1983). In this study, depression was measured as the value the participant scores on the Geriatric Depression Scale (Brink, Yesavage, Lum, Heersema, Adey, & Rose, 1982).

Assumptions

Several assumptions have been made throughout this study. First, it was assumed that nursing interventions could be planned and implemented to promote increased levels of self-esteem and decreased levels of depression in elderly patients. Second, it was assumed that the variables of depression and self-esteem were valid, meaning that the treatment of group reminiscence therapy would affect the dependent variables of depression and self-esteem. Third, as the sampling method used in the study was not one of random selection from a target population, it was assumed that there was a hypothetical population represented by the sample. This hypothetical population consisted of English speaking elderly patients at least 60 years old, who lived in an extended care center, who were able to hear normal conversation within a group, and who had minimal or no cognitive impairment.

CHAPTER TWO

REVIEW OF THE RELATED LITERATURE

Introduction

The reminiscence and reminiscence therapy literature from the disciplines of nursing, psychology, and psychiatry are reviewed. Both non-research (descriptive) and research literature were reviewed. The following topics from the literature are addressed: what reminiscence is and how it relates to life review, the purposes of reminiscence, what reminiscence therapy is, the purposes and benefits of reminiscence therapy, the potential negative effects of reminiscence therapy, and the conditions needed to most effectively carry out reminiscence therapy.

Definition of Reminiscence and its Relation to Life Review

Agreement exists across the literature concerning the definition of reminiscence. Reminiscence is described as an act, habit, or process of remembering past experiences (Havighurst & Glasser, 1972; King, 1982; McMahon & Rhudick, 1964). Life review is a naturally occurring process in which the elderly person recalls or reminisces about past experiences of significance. In life review, the person attempts to find meaning in the reminiscences (Butler, 1963; Molinari, & Reichlin, 1984-85; Poulton & Strassberg, 1986). The reminiscences may be silent and internal (solitary) or they may be shared with others verbally or in writing (interactive). Havighurst & Glasser claimed that reminiscence is universal at all ages after middle childhood (p. 245). They suggested that, with

increasing age, the person focuses more attention on the past and less on the future. No proof to validate this statement was presented, but the authors did suggest that further research was needed to support this claim. Thorton & Brotchie (1987), after reviewing the reminiscence literature, concluded that although a substantial proportion of elderly people reminisce, little empirical evidence existed to support the claim that older people reminisced more than persons in younger age groups (p. 96).

Reminiscences constitute the material or tools which the person uses to engage in the process of life review (Butler, 1963, 1975; Lewis, 1971). Life review does not necessarily take place in a sequential or structured manner, but rather, the person moves from reminiscence to reminiscence without attention to particular time or sequence of reminiscences.

Purposes of Reminiscence

Agreement was found across the descriptive literature as to the purposes and functions of reminiscence. Reminiscence was described as a process used to maintain or enhance self-esteem, stimulate thinking, enhance the process of life review, achieve ego integrity or acceptance of what life has been, raise one's status, communicate with others, and adapt successfully to aging (Boylin, Gordon & Nehrke, 1976; Butler, 1963; Lappe, 1987; Schnase, 1982). Beaton (1980) stated that there were at least four functions of reminiscences: validating, integrating, guiding, and connecting. The validating function of reminiscence enables the person to gain or maintain reassurance of their competence and worth. The

integrating function of reminiscence helps the person to interweave the past, present, and future simultaneously. Reminiscing can thus facilitate a sense of continuity of time and space for the individual. Through the guiding function of reminiscence, the older generation has the opportunity to provide direction to the younger generations. The elderly can teach or guide the younger generations by providing information, socializing the young, and helping to generally stabilize the culture. The connecting function of reminiscence facilitates the development of a link between the person and the environment. Through reminiscence, both messages and messages about messages (metacommunications) are exchanged.

Some support for the purposes or functions of reminiscence was found in the research literature. McMahon & Rhudick (1964) used a non-directive interview method to study the frequency and content of reminiscences, and the depression levels in 25 elderly Spanish-American war veterans. They found a non-significant trend for the non-depressed subjects to reminisce more than the depressed subjects. They tentatively suggested, based on these findings, that elderly people who reminisce more frequently might experience less depression than those who reminisce less frequently.

Havighurst & Glasser (1972) used a questionnaire to measure the frequency and affective quality of reminiscences of 300 middle-upperclass elderly. They found a significant correlation between high frequency of reminiscing and a positive affect (tone) of reminiscences, and a significant correlation of positive affect of

reminiscences and scores on a Life Satisfaction Index. Havighurst & Glasser tentatively concluded that they were unsure of which factor precipitated the others but that a syndrome or pattern of these three factors likely existed.

For the purpose of investigating whether those elderly who reminisced showed cognitive differences in the consistency of the self-concept from non-reminiscers, Lewis (1971) interviewed 23 elderly men who lived alone in the community. Lewis found that a significantly greater number of non-reminiscers regarded their pasts in negative terms than did those who reminisced. As well, Lewis found that when the reminiscers were confronted with a social threat (their opinions were challenged), they tended to reminisce and link their past to the present. Lewis concluded by suggesting that reminiscence may be a method the elderly use to maintain their self-esteem.

Boylin, Gordon & Nehrke (1976), used a reminiscence questionnaire and ego adjustment subscales (self-rating) with 41 elderly war veterans to investigate associations among reminiscence frequency, affect (tone), and ego adjustment. They found positive correlations between ego adjustment and frequency of reminiscence, and between ego adjustment and negative affect of reminiscences. They concluded by suggesting that reminiscing could serve an adaptive function for the elderly because it promoted successful adaptation to aging.

Though each of these studies was correlational in nature, and attempted to study relationships among the reminiscences of the

elderly with the variables of depression, self-esteem, life satisfaction, and ego adjustment, some evidence was found to support the potential benefits for the elderly who engage in reminiscence. However, based on a review of similar literature, Thorton & Brotchie (1987) claimed that the functions of reminiscence had not yet been empirically validated. They concluded that reminiscence may simply be a pleasurable and sometimes helpful activity for the elderly (p. 101).

Reminiscence Therapy

Reminiscence therapy is an intervention which can be used to guide individuals or groups of individuals to reminisce or recall events which occurred in the past (MacRae, 1982). Reminiscence therapy can be conducted with individuals or with groups. Individual reminiscence therapy may be carried out formally in a pre-planned meeting between the nurse or therapist and the patient, or it may take place more casually and occur as part of the interaction between the nurse and the patient at any point in time. Group reminiscence therapy is usually, but not necessarily, a planned intervention led by a therapist where group members share their reminiscences with others and engage in interactions about these reminiscences.

Though little attention has been given to exploring the differences between individual and group reminiscence therapy, more support has been given to group reminiscence therapy over individual reminiscence therapy as an intervention because of the potential added positive effects gained from the interpersonal

interaction and support within groups, and the economy of therapy costs in both time and money (Baker, 1985; Ellison, 1981; Herst & Moulton, 1985; King, 1982; McMordie & Blom, 1979; Parsons, 1986; Rosenthal, 1982). Few explanations have been postulated for claims of increased benefits of group reminiscence therapy over individual reminiscence therapy. In individual reminiscence therapy, the patient interacts with one other individual or therapist. The patient receives feedback and support from another person whose deliberate purpose for interacting is to provide support to the reminiscing patient. In group reminiscence therapy, participants receive and give feedback about past experiences from and to persons who interact voluntarily. Often, group participants have similar experiences. As well, group participants share the common present experience of living in the same environment or institution. Perhaps, the interactions among group reminiscence participants (which includes a group leader or therapist) takes on more meaning or has more effect than does interactions solely with a therapist. Each participant has the opportunity to gain more support for the validity and meaning of their past experiences within a group of peers rather than when interacting soley with a therapist.

Purposes and Benefits of Reminiscence Therapy

The following purposes and benefits of reminiscence therapy have been cited in the descriptive literature: to provide opportunities to engage in the life review process, to provide opportunities to interact, to maintain or increase self-esteem levels, to relieve

depression, and to promote ego integrity (Beaton, 1980: Ebersole, 1976, 1978; Ellison, 1981; King, 1982; Leszcz, Feigenbaum, Sadavoy, & Robinson, 1985; MacRae, 1982). The literature, discussed below, which reported on research carried out to test the effectiveness of reminiscence therapy as an intervention has provided some support for the above proposed purposes.

With a non-probability sample of 16 elderly residents in a long-term geriatric facility, Hala (1975) investigated whether reminiscence group therapy of one hour weekly meetings would promote self-esteem and socialization of resident participants. Hala presented very favourable conclusions concerning the increased socialization of participants within and outside the therapy groups. However, apart from subjectively concluding that group reminiscence members were more easily able to express their feelings and interact with others more frequently after participating in the group, little empirical organized data was presented to support these conclusions.

In order to investigate the effects of group reminiscence therapy of weekly one hour sessions over six weeks, Baker (1985) implemented group reminiscence therapy with eight cognitively impaired women. Baker concluded that participants demonstrated improvement in verbal interaction, increased eye contact, increased touching of other members, increased smiling, increased acceptance of leadership roles, and increased participation in activities over the six weeks, as measured on the "Evaluation Tool for Reminiscence Group Therapy" (p. 23). Though some of these conclusions may have

indicated decreases in levels of depression and increases in levels of self-esteem, this study report did not include any evidence of measurement of these variables to support the conclusions. Apart from the general conclusions described above, a summary of the results collected from this tool was not presented.

Using a pre- and post-test experimental design, Parsons (1986) investigated the effects of group reminiscence therapy on the levels of depression in a convenience sample of nine elderly women who lived in a government funded housing facility. Levels of depression were measured using the Geriatric Depression Scale (GDS). A significant decrease in levels of depression (measured by the GDS) was found after subjects participated in group reminiscence therapy for a period of six weeks. The data was analyzed using a paired t-test of mean depression scores from the pre-test to the post-test time period ($t=8.03$, $d.f.=8$, $p.< 0.0005$). Parsons concluded that, even though generalizability of the findings was limited, the findings did provide evidence that group reminiscence therapy may be an effective intervention to treat depression in elderly patients.

Lappe (1987) investigated the effects of group reminiscence therapy on levels of self-esteem by employing a pre-test and post-test experimental design incorporating a control group. Specifically, Lappe compared the effects of group reminiscence therapy with current events discussion groups on participants' levels of self-esteem. The Rosenberg Self-Esteem Scale (RSE) was used to measure the dependent variable of self-esteem. The study

consisted of a non-probability sample of 83 elderly institutionalized adults with a mean age of 82.6 years. Subjects were randomly assigned to either the group reminiscence group or the current events group. Eight groups of eight to fourteen members were formed. To compare the effects of the frequency of group meetings, four groups met once a week and four groups met twice a week for a period of ten weeks. Using a repeated measures analysis of variance to analyze the data, Lappe found a significantly greater increase in self-esteem scores across time (pre-test to post-test) in participants who received the group reminiscence therapy ($F=10.30$, $d.f.=1$, $p.< 0.05$), with no significant interaction between time and frequency of group sessions (p. 15). As well, when the interaction of group with frequency of group meetings were analyzed, there was a significant increase in self-esteem scores for both reminiscence groups and for the current events group that met once weekly ($F=5.44$, $d.f.=1$, $p.< 0.05$). The current events group which met twice weekly demonstrated a non-significant decrease in levels of self-esteem. Lappe concluded that the findings suggested that the intervention of group reminiscence therapy produced the significantly greater increases in self-esteem among elderly patients.

The effects of the treatment of "one-to-one" (nurse-patient) life review interactions on the life satisfaction of 12 elderly patients was investigated by Haight & Bahr (1984). Subjects were randomly assigned to either an experimental group who received six life review therapy sessions using structured reminiscing over a

period of thirty days, or a control group who received six social visits over the same thirty days. The dependent variable of life satisfaction was measured by the Life Satisfaction Index (LSI-A), a self-rating attitude scale consisting of 18 questions. Using pre-test LSI-A scores as a covariate, an analysis of covariance found a significant increase in life satisfaction in the experimental group which received life review therapy ($F=57.47$, $d.f.=1,8$, $p.< 0.05$). Subjects in the control group demonstrated a mean decrease in life satisfaction ratings of -0.833 from the pre-test to the post-test time period. No discussion was presented as to whether this finding was a significant difference. The Life Satisfaction Index used in this study was described as measuring five components which constitute life satisfaction: zest, resolution and fortitude, congruence between desired and achieved goals, positive self-concept, and mood tone. This index appeared to attempt to measure self-esteem and perhaps even depression, but it is not known to what extent, nor how well these two specific variables were measured by the LSI-A. Therefore, though this study did not offer any direct evidence as to the effects of individual life review or reminiscence therapy on the levels of self-esteem and depression in the elderly, some indirect support was provided.

Contrasting results were found by Perotta & Meacham (1981) in a study of 21 community residents who participated in one of three situations for five weeks: individual reminiscence therapy, discussion of current life events, and no treatment. Using a repeated measures analysis of variance, no significant differences

were found for participants in any of the three treatment groups on the dependent variables of self-esteem (measured by the Rosenberg Self-Esteem Scale) or depression (measured by the Zung Depression Scale) from the pre-test to the post-test time period. These findings did not support the effectiveness of individual reminiscence therapy as an intervention promoting increased self-esteem and decreased depression in the elderly. However, as previously discussed, it is important to consider that the reminiscence therapy used in this study was individual, and not group reminiscence therapy. These two types of reminiscence therapy may not have the same effects on patients.

In an attempt to qualitatively investigate the relationship of the life history process and health in the elderly, Bramwell (1984) interviewed 8 elderly persons who lived independently in an urban community. In these interviews, Bramwell assisted the participants to engage in life review in a one-to-one interview situation, an individual reminiscence intervention. The author stated that some patterns or themes were found among subjects when engaging in life history or review, and that these individuals who participated in life history experienced movements across time that occupied an entire life space. The author then defined health as expanded consciousness. Bramwell concluded that because reminiscence and life review were vehicles for the expansion of consciousness, life review promoted health. At the end of the research report, the author added that the Rosenberg Self-Esteem Scale had been used to test the levels of self-esteem at the prestudy and poststudy time

periods. No significant differences were found on self-esteem from the prestudy to the poststudy times. However, the author stated that "all prescores were high." No further information was provided, probably because it appeared (though not explicitly stated) that the purpose of the study was to gather information as to the themes of reminiscence and life review rather than to study the effects of life review.

Potential Negative Effects of Reminiscence Therapy

The descriptive literature highlights several potential negative effects of reminiscence therapy. According to some authors, excessive reminiscence may lead to avoidance of life's realities (King, 1982; Leszcz, Feigenbaum, Sadavoy, & Robinson, 1985; Poulton & Strassberg, 1986). It has been stated that reminiscence may lead to feelings of despair, guilt, and grief over the past which may cause depression and even lead to suicide (Beaton, 1980; King, 1982; Leszcz, Feigenbaum, Sadavoy, & Robinson, 1985; McMordie & Blom, 1979; Poulton & Strassberg, 1986; Sullivan, 1983). However, even though McMordie & Blom (1979) acknowledged that these negative effects may be related to reminiscence, there has been no empirical demonstration that this is so. None of the reviewed study reports, which described the testing of reminiscence therapy as a nursing intervention, identified or even suggested that any potential negative effects may have accrued to the elderly who participated in reminiscence therapy.

Conditions Needed to Carry Out Group Reminiscence Therapy

To ensure that reminiscence therapy groups are most effective, several conditions should be considered before implementation of the groups. These conditions relate to the group leader or therapist, who should participate, the setting, the size of the group, and the frequency and duration of group meetings.

In the reviewed literature, it was suggested that the reminiscence group leader be knowledgeable about reminiscence therapy; its purposes, benefits, potential negative effects, and how to structure and lead the group; and possess positive attitudes about reminiscence therapy (Sullivan, 1983). The group leader or therapist should also be a particularly good listener (Butler, 1974; Lappe, 1987; Lewis & Butler, 1974; Sullivan, 1983). In group reminiscence therapy, the group leader should be knowledgeable about group process and dynamics, and possess skills to facilitate effective group work to promote attainment of group and individual patient goals. Some of the specific tasks of the group leader usually include the following: gathering the group, refocusing comments, making linking statements between one participant and another, including all members in interactions, reviewing previous sessions at the beginning of each session (summarizing), introducing discussion topics or asking the members for topic suggestions, and sharing some of their own past experiences and memories (Matteson, & Munsat, 1982; Rosenthal, 1982). Burnside (1976) and Ebersole (1976) suggested that another important task of the group leader was to carry out measures to promote attendance of

group participants by providing snacks and beverages during group meetings. Not only were snacks thought to act as motivators to attend, but sharing food and drink when interacting with others was considered to be an important social norm which should be carried over to these groups. It was felt that external motivators such as snacks were important in promoting attendance when groups were new or in the beginning stages of development, but became less important motivators as participants began to discover other internal or personal reasons to participate in the group.

McMordie & Blom (1979) and Sullivan (1983) suggested that any elderly patient could benefit from participating in reminiscence therapy, despite their level of cognitive or physical functioning. Burnside (1976) cautioned about mixing patients in groups who are alert with patients who are not cognitively alert. She stated that it may be too difficult to keep all group members interested. As well, feelings of frustration by group members may interfere with achieving the goals of participation in the group. Thus, it was suggested that when planning reminiscence groups, members should be at a similar level of cognitive functioning.

Reminiscence therapy, either individual or group, can be carried out in a wide variety of settings. Reminiscence therapy can take place in the community in places such as senior citizen centers, health clinics, senior apartment complexes or the homes of the elderly. Reminiscence therapy can easily be carried out within nursing homes or long-term care settings, senior day care centers, or any other facilities where elderly patients live (Butler, 1974;

Ebersole, 1976; Lappe, 1987; Parsons, 1986). Ebersole (1978) suggested that group reminiscence therapy be structured to meet at the same time and place every week so that the meeting becomes an anticipated event that can be counted on (p. 247). The setting for reminiscence groups should also be one of comfort for participants (e.g., temperature, lighting, seating). The environment should be pleasant and comfortable so that participants are encouraged to attend the group meetings.

When implementing group reminiscence therapy, the size of the group is an important consideration. Most authors suggested formation of small groups ranging from four to ten group members. Six group members has most often been cited as the ideal group size (Burnside, 1976; Ebersole, 1978; McMordie & Blom, 1979). The size of the group should be kept small to facilitate participation and interaction among members, and to allow for close physical proximity of members.

The frequency of reminiscence group meetings and the length of time for participation are important considerations when planning reminiscence groups. Most authors recommended that reminiscence groups meet once weekly for approximately one hour (Baker, 1985; Hala, 1975; Lappe, 1987; Leszcz, Feigenbaum, Sadavoy, & Robinson, 1985; McMordie & Blom, 1979). It was suggested that one hour meetings were long enough to accomplish effective group work, but not too long as to be uncomfortable for participants. Lappe (1987) compared the effects on levels of self-esteem between those participants in group reminiscence who met once weekly and those

who met twice weekly. The results showed that those who participated in group reminiscence sessions twice weekly did not demonstrate greater scores on levels of self-esteem than those who participated only once weekly. The period of time over which reminiscence groups met ranged from six weeks (Baker, 1985; Parsons, 1986) to ten weeks (Lappe, 1987; McMordie & Blom, 1979). Some groups carried on indefinitely over years, with group members changing over time (Hala, 1975; Leszcz, Feigenbaum, Sadavoy, & Robinson, 1985). Those authors who suggested limited periods for participation in reminiscence therapy were not suggesting that participants only needed a certain amount of time in reminiscence therapy, but rather that the benefits of reminiscence therapy could be empirically validated over a short period of time.

Summary

From the literature reviewed, it was suggested that reminiscences are valuable tools for the elderly to use to engage in life review. There was some evidence presented which provided support for the following tentative conclusions: that elderly who reminisce may be less depressed than elderly who do not reminisce (McMahon, & Rhudick, 1964), that reminiscing may serve an adaptive function for the elderly by promoting successful adaptation to aging (Boylin, Gordon, & Nehrke, 1976), that high frequency of reminiscing, a positive tone of reminiscing, and life satisfaction are positively correlated (Havighurst, & Glasser, 1972), and that reminiscing may be a method that elderly use to maintain self-esteem (Lewis, 1971).

It has been suggested that reminiscence therapy is an

effective intervention to use with elderly patients to help them experience decreased feelings of depression (Parsons, 1986) and increased feelings of self-esteem (Haight, & Bahr, 1984; Lappe, 1987). There has not been any demonstration of empirical evidence suggesting potential negative effects of reminiscence therapy, though potential negative effects have been suggested in the descriptive literature reviewed.

Certain conditions, to maximize the effectiveness of reminiscence groups, have been suggested in the reviewed literature. It has been suggested that the group leader be knowledgeable about reminiscence therapy and group dynamics, and possess the skills needed to facilitate effective group work. It has also been suggested that group members be at a similar level of cognitive functioning, that the setting of the group meeting be comfortable and pleasant, that the size of the group be small (e.g., between four to ten members), that groups meet for about one hour weekly, and that the effects of reminiscence group therapy could be empirically validated within a short period of about six weeks.

CHAPTER THREE

METHOD AND PROCEDURES

Design

This study employed a pre-test, post-test, control group experimental design. An experimental design seemed the best method to answer the research question asked in this study and to gather evidence for supporting or not supporting the hypotheses being tested. The experimental design has both strengths and weaknesses. Its greatest strength is that this design is the most powerful method to test cause-and-effect relationships between variables. The relevant major weaknesses of an experimental design are the potential for artificiality in the study, and the potential for the occurrence of the "Hawthorne effect" (Polit & Hungler, 1985, p.103). This study was a field experiment occurring in the natural setting of an extended care center rather than in a laboratory. Thus, the potential weakness of artificiality was not a great concern in this study. The "Hawthorne effect" resulting from subjects knowing that they were involved in an experiment or a study could potentially have acted to obscure the effects of the treatment variables on the measured dependent variables. However, if such an effect was present in this study, it was likely that the "Hawthorne effect" acted on all three groups in a similar manner.

The three necessary elements of an experimental design were incorporated in this study. The independent or treatment variable in this study was group reminiscence therapy. Two control groups

were also employed as part of the manipulation or treatment - a current events discussion group, and the other group which received no intervention. The subjects in the reminiscence groups met for about one hour weekly over a period of eight weeks. The subjects in the current events discussion groups also met for about one hour weekly over the same eight week period. The subjects in the group which received no intervention did not participate in any treatment condition over the same time period.

After the sample was gathered, each of the thirty-seven subjects was randomly assigned to one of the three experimental groups. Randomization resulted in the assignment of thirteen subjects to the reminiscence group, twelve subjects to the current events group, and twelve subjects to the no intervention group. As groups of this size were too large to promote effective communication among members, especially with elderly patients such as in this sample who have decreased vision and hearing, the subjects in each of the reminiscence and current events groups were again randomly divided into two groups. Both randomization procedures were carried out by pulling subject names from a bag and systematically assigning them to a group. Thus, there were two reminiscence groups, and two current events groups. Each group met on either a Tuesday or a Wednesday afternoon from 1430 - 1530 hours. On each of these afternoons, a reminiscence group and a current events group met at the same time in two different sunroom locations. The researcher led both reminiscence groups and a graduate student led both current events groups.

The dependent variables were level of self-esteem, measured by the Rosenberg Self-esteen Scale (RSE), and level of depression, measured by the Geriatric Depression Scale (GDS). Pre- and post-treatment scores on both dependent variables were obtained for all subjects. All pre-testing of subjects was done within the one week preceding the first group meetings. All post-testing was carried out within one week following the last group meeting. Both pre- and post-testing were carried out between the hours of 1230 - 1800 hours to promote some consistency in the time of day in which subjects' levels of self-esteem and depression were being assessed. Even though subjects were encouraged to answer the questionnaires assessing self-esteem and depression on their own, only one of the subjects did so. The other subjects asked the researcher to read each of the questionnaires to them and fill in the answer of their choice. Most of these subjects were unable to either hold a pen to write, to see adequately to read the questions, or to read.

Data on other personal variables such as age and sex of the participant, frequency of social contacts, levels of completed education, and type of room accommodation were also collected. This data was recorded on the Subject Information Sheet which is illustrated in Appendix A. An illustration of the design of this study is presented below in Table 3.1.

SETTING

The setting for this study was an extended care center in a large western Canadian city. This center cared for 322 adult patients of all ages. These adults need varying amounts of nursing care for long

Table 3.1

STUDY DESIGN

R	O_1	X_1	O_2
R	O_1	X_2	O_2
R	O_1	X_3	O_2

-R refers to random assignment of subjects to one of three treatment conditions

-O_1 refers to pre-testing of subjects on dependent variables

-X_1 refers to the treatment condition of group reminiscence therapy

-X_2 refers to the treatment condition of current events discussion group

-X_3 refers to the treatment condition of no intervention

-O_2 refers to post-testing of subjects on dependent variables

periods of time. Patients in this center were classified as requiring either an auxiliary or a nursing home level of care. Auxiliary is a level of care for persons of all ages who do not require acute hospital care and treatment, nor an intensive program of rehabilitation. However, auxiliary patients do need regular and continuous medical attention and skilled nursing care on a 24 hour basis. This level of patient is funded by the government for 3.5 hours of care daily. Nursing home is a level of care in which intensive personal care with nursing supervision is required for the patient. The nursing home patient has physical or mental illness which is reasonably stabilized. Nursing home patients require personal care on a 24 hour basis, but not necessarily by a nurse. This level of patient is funded by the government for 1.6 hours of care daily.

The extended care center was a modern, bright, clean building with 4 storeys, an auditorium, a physiotherapy department, a small store, an accounting department, and a large enclosed courtyard with large outside windows. The striking physical feature of the center was the numerous large windows and dome ceilings allowing those inside to see the outside world, and those outside to see inside the extended care center.

Patient rooms were generally very personal and unique. Most patients had some of their own furniture, pictures of significant others on the walls and tabletops, and their own personal articles within their rooms or room areas. All patient rooms were private or semi-private. There were six large nursing units within the

center. Each unit had at least one, and usually two eating areas for patient meals or any type of solitary or group event. Most units had 3 bright sunrooms with glass bubble ceilings and walls at the end of each patient room area. It was in one of these sunrooms that each reminiscence and current events group met.

POPULATION, SAMPLE, SAMPLING

Ideally, the desired target population in this study was any patient who lived in an extended care facility who met the following criteria: at least 60 years of age, able to hear normal conversation within a group, and with minimal or no cognitive impairment. Strictly speaking, the target population is the entire group of cases from which the sample should be randomly selected, because it is about the target population which generalizations are made (Polit & Hungler, 1983, p. 238). However, the sample in this study was not a random sample of all cases from the ideal target population. Therefore, an assumption has been made that the sample was representative of a hypothetical population meeting the previously described criteria for the ideal target population. The accessible population was any patient in the extended care setting who met the following criteria:

1. was at least 60 years of age;
2. could hear normal conversation within a group;
3. could speak English;
4. achieved a score of 8 - 10 on the Mental Status Questionnaire (MSQ) (Kahn, Goldfarb, Pollack, & Peck, 1960)

5. agreed to participate in the study and gave informed written consent.

Although it was originally planned that the sample would be randomly selected from an accessible population of about 100 possible subjects within the center, the sample became a non-probability sample of 37 patients because it was not possible to obtain a random sample. Before the sampling procedure began, the director of nursing and the unit supervisors in the extended care center compiled a list of potential subjects thought to meet the sample criteria. This list consisted of the names and room numbers of 102 patients. Those patients from the list who had been approached but who did not participate in the study did not participate for the following reasons: could not hear adequately during the initial interview with the writer (20 patients), could not speak English (4 patients), achieved a score of less than 8 on the MSQ (12 patients), or would not agree to participate in the study (29 patients). Reasons given for refusing to participate in the study were commonly the following: "I am too busy", "I am not well enough", and "I don't like groups". The researcher also felt that there were at least two other common reasons for refusal of participation, though these possible reasons were never validated with the potential subjects. First, potential subjects may have been reluctant to sign a consent form, even when the reasons for consent were carefully explained to the patient. Some patients seemed eager to participate until they were asked to give their written consent. These patients seemed suspicious of signing such

a document. Second, some patients may have been reluctant to participate because the researcher was, at that time, an outsider and still relatively unknown in the extended care center.

The sample consisted of 37 subjects between the ages of 60 and 98 years. The mean age for the entire sample was 78.97 years. There were 9 males in the sample and 28 females. With regard to marital status, 1 subject was single, 9 subjects were currently married, 23 subjects were widowed, and 4 subjects were divorced. The years of formal education completed by subjects ranged from 3 to 16 years with a mean of 9.00 years. With regard to the type of room accommodation, 7 subjects lived in a private room and 30 subjects lived in a semi-private room. The amount of phone calls given and received by each subject within one week were reported as ranging from 0 - 70, with a mean of 6.5 weekly phone calls. Subjects reported a range of weekly visits from 0 - 10, with a mean of 2.7 weekly visits with significant others. Subjects reported a range of frequency of weekly outings from 0 - 2, with a mean of 0.7 weekly outings. The length of hospitalization for all subjects ranged from 0.17 - 16.00 years, with a mean stay of 3.99 years. Summary tables of the mean or frequency, the range (if appropiate), and the standard deviation (if appropriate) of each of these descriptive personal variables for the entire sample, the reminiscence group, the current events group, and the no intervention group are presented below, in Table 3.2.

Table 3.2

Summary of Personal Variables

AGE

	mean	range	standard deviation	number
all sample	78.97	60 - 98	10.38	37
reminiscence	76.80	62 - 91	8.73	13
current events	80.00	63 - 96	11.61	12
no intervention	80.20	60 - 98	11.23	12

SEX (frequency)

	males	females
all sample	9	28
reminiscence	3	10
current events	3	9
no intervention	3	9

MARITAL STATUS (frequency)

	single	married	widowed	divorced
all sample	1	9	23	4
reminiscence	1	3	8	1
current events	0	3	7	2
no intervention	0	3	8	1

YEARS OF EDUCATION

	mean	range	standard deviation
all sample	9.00	3 - 16	3.46
reminiscence	9.85	3 - 16	3.89
current events	7.83	3 - 13	2.59
no intervention	9.25	3 - 14	3.55

TYPE OF ACCOMMODATION (frequency)

	private	semi-private
all sample	7	30
reminiscence	1	12
current events	2	10
no intervention	4	8

WEEKLY PHONE CALLS

	mean	range	standard deviation
all sample	6.50	0 - 70	11.97
reminiscence	9.60	0 - 70	18.66
current events	2.33	0 - 8	2.54
no intervention	7.20	0 - 21	7.17

WEEKLY VISITS

	mean	range	standard deviation
all sample	2.70	0 - 10	2.25
reminiscence	2.70	1 - 9	2.41
current events	2.30	0 - 8	2.02
no intervention	3.10	1 - 10	2.58

WEEKLY OUTINGS

	mean	range	standard deviation
all sample	0.57	0 - 2	0.65
reminiscence	0.70	0 - 2	0.75
current events	0.60	0 - 2	0.67
no intervention	0.40	0 - 2	0.52

YEARS OF HOSPITAL STAY

	mean	range	standard deviation
all sample	3.99	0.17 - 16.0	3.78
reminiscence	4.50	0.25 - 13.0	3.94
current events	3.49	0.17 - 16.0	4.52
no intervention	3.94	0.42 - 8.50	2.99

With the exception of the variables "weekly phone calls" and to a lesser extent, the "years of education", each of the treatment groups appeared quite similar on the personal variables compared to each other and with the entire sample taken together. For this reason, no inferential statistical tests were done to gather evidence of statistical differences between the treatment groups with respect to these variables. It was concluded that the groups appeared similar in the relevant personal variables. All subjects who initially agreed to participate in the study, stayed in the study for its duration. All the subjects but one attended at least five of the eight treatment group meetings. One subject in the current events group only attended one of the eight group meetings. The subject did not wish to be excluded from the study. The subject's excuses for not attending were "I can't hear well enough.", "I don't feel well enough." or, "I have other plans." Because this subject had similar scores on the pre-tests compared to the pre-tests (as did most of the other participants in the current events group), this subject was included in all of the data analyses.

INSTRUMENTS

Three data collection or measurement instruments were used in this study: the Mental Status Questionnaire (MSQ) (Kahn, Goldfarb, Pollack, & Peck, 1960), the Rosenberg Self-esteem Scale (RSE) (Rosenberg, 1965), and the Geriatric Depression Scale (GDS) (Brink, Yesavage, Lum, Heersema, Adey, & Rose, 1982). The MSQ was used as a screening device during the sampling procedure to ensure that all

subjects had either no or mild cognitive impairment. The RSE was used to measure subject levels of self-esteem before and after the treatment condition. The GDS was used to measure subject levels of depresaion before and after the treatment condition.

Mental Status Questionnaire

The MSQ is a brief objective and quantitative measure used to assess mental status. It was originally developed to assess the mental status of individuals older than 65 years of age. The MSQ consists of 10 items which test orientation and recall of personal and general information (Kahn, Goldfarb, Pollack, & Peck, 1960). This tool was easily verbally administered to potential subjects within 2-3 minutes. The range of possible scores is 0-10. Each correct answer is awarded a score of 1 point. A score of 0-1 suggests severe chronic brain syndrome, a score of 2-7 suggests moderate organic brain syndrome, and a score of 8-10 suggests either no or mild chronic brain syndrome (Mangen, & Peterson, 1984, p. 289). The lower the score, the greater the cognitive impairment. The MSQ is illustrated in Appendix B.

In a study of 230 elderly patients who received a pre-admission assessment of mental functioning, Wilson & Brass (1973) found that the MSQ was a highly discriminating test of mental functioning after finding a correlation of -0.82 with the Dementia Rating Scale. Kim (1986) used the MSQ in a study with 105 institutionalized elderly and found a reliability coefficient for internal consistency of 0.73 (KR-20). In a study designed to validate the usefulness of screening methods for mental health

difficulties of the elderly, Cresswell & Lanyon (1981) found a correlation of -0.87 (Pearson's r) between the MSQ and organicity criteria ratings made by two psychiatrists. Content, concurrent, and construct validity of the MSQ have been well-established (Cresswell & Lanyon, 1981; Kahn, Goldfarb, Pollack, & Peck, 1960; Wilson & Brass, 1973).

Rosenberg Self-Esteem Scale

The RSE is a ten-item self-rating scale measuring global self-esteem or self-worth. The scale consists of 10 items or statements of both positive and negative self-esteem or self-worth. This scale was easily administered and completed within 3-5 minutes. For each of the ten items, there are four response categories: strongly agree, agree, disagree, and strongly disagree. The respondent was asked to choose the response which reflected the amount of agreement held with the item or statement. Five items are statements of positive self-worth (numbers 1,3,4,7,10). For these items, a score of 4 was given for the response "strongly agree", 3 points for the response "agree", 2 points for the response "disagree", and 1 point for the response "strongly disagree". The remaining five items are statements of negative self-worth (numbers 2,5,6,8,9). For these items, a score of 1 was given for the response "strongly agree", 2 points for the response "agree", 3 points for the response "disagree", and 4 points for the response "strongly disagree". The possible range of scores is 10-40. The higher the score, the more positive is the respondent's level of self-esteem. The RSE is illustrated in Appendix C.

Though originally developed as a screening device to assess the level of self-esteem within adolescents, the RSE has been frequently used to assess the self-esteem of elderly persons. It has been demonstrated that the RSE has a reproducibility coefficient of 0.92 (Rosenberg, 1965). Sibler & Tippett (1965) reported that the RSE had a test-retest reliability of 0.85 (Pearson's r) over two weeks with a sample of 28 subjects. Ward (1977) reported that the RSE demonstrated an inter-item reliability coefficient of 0.74 (Cronbach's alpha) when used to assess the global self-esteem of 323 non-institutionalized elderly American adults. Rosenberg (1965) convincingly discussed the evidence for face validity of the RSE. Evidence of convergent validity of the RSE was reported by Sibler & Tippett (1965) when correlations of 0.67 and 0.83 (Pearson's r) were found between the RSE and two other measures of self-esteem. When used to assess the self-esteem of 28 psychiatrically ill adults, the RSE correlated 0.63 ($p < 0.001$) (Pearson's r) with the "Attitude Toward Self Scale" on the "Progress Evaluation Scales" (Green, Wehling, & Talsky, 1987).

With respect to common average scores obtained on the RSE for elderly persons, Ward (1977), in a sample of 323 non-institutionalized persons with a mean age of 74.1 years, found a mean score of 29.4 on the RSE and a standard deviation of 3.07. Lappe (1987) also used the RSE to assess the level of self-esteem of 83 elderly patients in four long-term care institutions in the United States. The mean age of the subjects was 82.6 years. Although the mean of all patient scores was not presented, the mean RSE score for each

of the four treatment groups (pre-tests) was 27.5, 28.2, 28.5, and 29.5.

Geriatric Depression Scale

The GDS is a thirty-item self-rating questionnaire which measures the level of depression in the elderly person. The GDS contains thirty dichotomous questions requiring a yes or no answer. Twenty of the thirty questions indicate depression when answered positively, while the other ten questions indicate depression when answered negatively. A score of 1 is only given if the respondent answers "yes" to questions 2, 3, 4, 6, 8, 10, 11, 12, 13, 14, 16, 17, 18, 20, 22, 23, 24, 25, 26, 28; or if the respondent answers "no" to questions 1, 5, 7, 9, 15, 19, 21, 27, 29, 30. The higher the score on the GDS, the higher is the respondent's level of depression (Yesavage, Brink, Rose, Lum, Huang, Adey, & Leirer, 1983). The GDS is illustrated in Appendix D.

The GDS was intentionally developed to screen for depression within elderly persons. The GDS has demonstrated a high degree of internal consistency. Tests to measure the internal consistency of the GDS yielded an alpha coefficient of 0.94 (Cronbach's) and a split-half reliability coefficient of 0.94 (Spearman-Brown formula). Test-retest reliability, spaced one week apart for 20 subjects, was 0.85 ($p<0.001$) (Yesavage, Brink, Rose, Lum, Huang, Adey, & Leirer, 1983). A "convergent validity" for the GDS was supported when correlations of 0.83 ($p<0.001$) were found between the GDS and the Hamilton Rating Scale for Depression (HRS-D), and 0.84 ($p<0.001$) between the GDS and Zung Self-Rating Depression

Scale (SDS). The correlation between the SDS and the HRS-D was 0.80 ($p<0.001$) (Yesavage et al., 1983). Both the HRS-D and the SDS have received previous support as being valid measures of depression (Hamilton, 1960; Zung, 1965).

Common average scores for the GDS have been established. With a sample of 51 elderly depressed persons, the mean score on the GDS was 19.20 with a standard deviation of 7.08. The mean score on the GDS for a sample of 20 "normal' or non-depressed elderly was 5.00 with a standard deviation of 3.63 (Brink, Yesavage, Lum, Heersema, Adey, & Rose, 1982). These authors suggested that the normal range of depression, as measured by the GDS, for elderly persons is 0-10. Parsons (1986) used the GDS as a pre-test and post-test to measure levels of depression with 6 non-institutionalized elderly subjects. The mean pre-test score on the GDS was 14.00 with a standard deviation of 3.21.

PROCEDURE

Once ethical approval had been granted by the Faculty of Nursing of the University of Alberta and the extended care center in December, 1987, formal entry into the extended care setting was gained at the begining of January 1988. Sampling began on Saturday, January 9, 1988. The director of nursing and the unit supervisors had compiled a list of potential subjects believed to meet the sample criteria. This list contained the names and room numbers of 102 patients. It was originally planned that the sample would consist of a random sample of subjects from this list of potential 102 subjects. The sample consisted of any patient on the

list who agreed to participate and who met each of the sampling criteria. Sampling was a lengthy procedure which took 7 full days to complete. By the end of the procedure, the researcher felt quite comfortable, welcome, and known in the center. Patients and staff smiled and stopped to talk with the researcher; relationships were being established. During the sampling procedure, each potential subject was approached individually and privately by the researcher to hear an explanation of the nature and purpose of the study. At this time potential participants were encouraged to ask any questions about the study or their possible participation in the study. The researcher answered these questions honestly and tried to portray an attitude of excitement about the study. If the potential subject agreed to participate in one of the three randomly assigned treatment groups, the person was asked to sign the consent. Once the consent was signed, the researcher administered the MSQ. If the potential subject received a score of less than 8, the consent was destroyed and the patient was thanked for their consideration. If the potential subject received a score of 8-10, the person was asked questions to gather the data on the personal variables which was recorded onto the "Subject Information Sheet" (Appendix A). Each subject readily volunteered this information. The researcher then told the subject tentative dates when the pre-testing would be done, when the random choice of groups would be made, and when the groups might begin. The sampling procedure was completed on January 19, 1988. The sample consisted of 37 subjects.

Random assignment of subjects was carried out by pulling subject names from a bag, and systematically assigning the pulled name to one of the three groups in a consecutive method. Because groups of 12 or 13 were too large, each treatment group was again randomly subdivided into two groups. The researcher compiled lists of patient names, group assignment, day and time of group meeting, and place of group meetings for the director of nursing and for each unit. It was hoped that if staff knew when and where patients were to meet for their group, they could be helpful in promoting subject attendance. A large index card was made for each subject in the current events group and the reminiscence group including the following information: the subject's name, the group assignment, the day the group meets, the time of the group meeting, and the location of the group meeting.

Pre-testing was done between January 20 and January 23. All pre-testing was carried out between 1230-1800 hours to ensure consistency in the time of day in assessing subject levels of self-esteem and depression. With the exception of one participant who agreed to complete the pre-test questionnaires on her own, all pre-tests were administered to subjects by the researcher. Privacy was maintained during pre-testing. Subjects were interviewed in the privacy of their rooms or privately in a sunroom. The researcher read the preceding instructions for the assessment tool, and then read each item to the participant. The participant was encouraged to take the necessary time to state their chosen response. When administering the RSE, if the subject answered

"disagree" or "agree", the researcher prompted by saying "disagree or strongly disagree?" or by saying "agree or strongly agree?" This was done to ascertain that the subject discriminated between the degrees of agreement or disagreement. Those patients who chose either of the extreme responses without prompting was already discriminating between the degrees of the responses, and therefore, did not need prompting. The GDS seemed to be easily completed by the subjects. Subjects did not need help to formulate their responses of "yes" or "no".

Once the participant completed both the pre-tests, they were told which group they had been assigned to, what day the group met, the time the group met, and where the group met. Each participant was given the index card with this information. Most subjects posted this card on their bulletin board beside their bed, or on their bedside table so they could make quick reference to the card. Participants in the current events groups and the reminiscence groups were told that the researcher would come early and remind them of their group on the day of their group meeting. Any further questions that subjects may have had about their participation were answered then. Subjects were again thanked for their participation. Each participant was very cooperative during the pre-test interview. Participants answered thoughtfully to each question on the data collection tools.

The groups met once a week (on either a Tuesday or Wednesday afternoon from 1430-1530 hours) for eight consecutive weeks starting the week of January 25, 1988. The commencement of the groups

was timed exactly with the beginning of a nurses' strike. Nurses at this extended care center participated in this strike. Before the first group meeting, the researcher introduced the group leader for the current events group to each current events group member. For the first three weeks, the researcher and the leader of the current events group spent one to one and one-half hours preceding each group meeting looking for patients to remind them of the group meeting, helping them prepare to come to the group, and transporting them to the group meeting. After these first three weeks, much less time was needed to encourage subjects to attend. Usually, subjects were already waiting for the researcher to transport them to the meeting or they transported themselves to the meeting place.

Throughout this eight week treatment period, no formal contact was made between the researcher and members of the no intervention control group. The researcher often met these participants within the center. Interactions with these subjects were kept to a minimum, such as exchanging greetings.

The final week of treatment delivery was the week of March 14, 1988, with the last groups meeting on either Tuesday, March 15, or Wednesday, March 16. The post-testing of all subjects was completed by March 18. With the exception of one participant who agreed to complete the post-tests on her own, all post-testing was administered by the researcher. The post-test interviews were carried out in the privacy of each subject's room or privately in a sunroom. The post-test questionnaires were administered between

1230-1800 hours as were the pre-tests. The adminstration procedure was the same as that used for pre-testing. The same method of prompting was used if needed. During the post-test interview, the researcher also reassured each participant of anonymity and confidentiality of the information obtained, and thanked them for their valuable participation in the study.

GROUP TREATMENTS

Current Events Discussion

The current events group subjects met once weekly to discuss current events occurring in the world at that present time. These events often related to the lives of the subjects in the groups or to the world at large. One of the most frequent topics was that of the food served to the patients in the center. A second common topic of discussion, especially during the first four weeks, was that of the nurses' strike which had occurred during the first three weeks of the treatment period. The topics discussed were quite diverse. Topics ranged from sports to free trade for Canada and the United States. Usually at the beginning of each group, participants were welcomed to the group, and offered something to eat and drink. The researcher provided home baked "goodies" for each group meeting. The group leader then proceded to highlight the first pages of that day's local newspaper. The group leader read some of the articles out loud and invited participants to offer their comments or ideas related to the topic. Participants were more willing to share their opinions and ideas after the group had met several times. When participants started to reminisce, the

group leader redirected the conversation back to the present topic. These groups tended to meet for about 45 minutes for each group meeting.

Group Reminiscence

The reminiscence group subjects met once weekly to recall and discuss past memories of their experiences and feelings. At the beginning of each group, participants were welcomed and the reasons for absent members was given. The group usually discussed how their past week had been while participants were offered home baked "goodies". For the first three weekly meetings the researcher pre-planned topics for group discussion. Less threatening topics were planned because it was felt that participants did not yet feel comfortable discussing feelings and events which have great personal meaning. Topics such as "The hardest thing about being a parent was _____." or "The longest trip I ever took was _____." were first discussed. At this point, subjects generally participated by sharing information. Some feelings were shared but other group members tended to simply listen to these expressions of feelings without showing any overt reactions nor giving any feedback to the person about these feelings. The researcher demonstrated this task of giving the person feedback about the expressed experiences and feelings by being empathic, seeking clarification, paraphrasing, etc. By the third and fourth weeks, both groups were already choosing their own topics for discussion. Participants began to share more of their personal experiences and feelings. As well, group members themselves began to fulfill the

group tasks of giving feedback to each other about the experiences and feelings expressed. Group members began to say things to each other such as "That must have been so sad for you. You must be very strong to have survived that." Many of the topics discussed related to happy events in the participants' lives but at least as many related to sad or difficult events in their lives. A common topic of discussion in these groups was that of life in the "hungry thirties". All of the subjects had lived in Canada during that period and thus had a common ground of experiences. Participants engaged in a common theme of discussing how difficult it was to survive that period, but that they all indeed had done so. They tended to bring out the strengths in each other even in the face of such adversity. Even though these groups were planned to meet for one hour at a time, members were usually reluctant to end the group session before one and one-half hours.

ETHICAL CONSIDERATIONS

Informed written consent was obtained from each potential subject before the potential subject was allowed to participate in the study. Patient subjects were informed about the purpose and content of the study, the general procedures of the study, their freedom to withdraw from the study without recrimination at any time, confidentiality and anonymity of the data which was obtained, and the risks and benefits related to participation in the study. The informed consent form used in the study is illustrated in Appendix E. Potential subjects were asked to sign two copies of

the consent form so that they could retain one copy as an information sheet.

The "University Policy Related to Ethics in Human Research" (1985), and the Canadian Nurses Association "Ethical Guidelines for Nursing Research Involving Human Subjects" (1983) were strictly adhered to in this study. Ethical approval for this study was sought and obtained from the Faculty of Nursing "Ethics Review Committee" of the University of Alberta and from the extended care center in December, 1987.

During the planning stages for this study, it had been decided that if either of the group leaders or any staff member observed any behaviors in participants that may be considered negative effects associated with reminiscence therapy (eg., increased depression), serious consideration would be given to discontinuing the treatment for that subject. Also, emotional support was to be provided for the subject by the nurse-therapist and plans would be made with the subject and hospital staff about how to resolve the patient problem. On pre-testing, six subjects had scores on the GDS greater than 20, suggesting high levels of depression. In five of these six cases, subjects with high depression scores also demonstrated low RSE scores, which suggested these subjects also had feelings of low self-esteem. There were two cases from each of the three treatment groups. The researcher shared these observations with the director of nursing in the agency. The director indicated that this was known by the staff because of the clinical signs demonstrated by these patients. It was decided that no

action would be taken other than closely monitoring these patients for signs of worsening depression or lower levels of self-esteem. Only one of the patients in the no intervention control group demonstrated clinical signs of increased depression during the post-test interview (e.g., crying, sobbing, openly expressing feelings of sadness). These observations were communicated to the director of nursing.

As planned, the researcher communicated with and reported directly to the director of nursing in the extended care setting. The general progress of the sessions, the potential effects of the treatment groups, and observations related to the progress of any of the subjects in the reminiscence or current events groups was discussed.

Both nurses who led the groups were well qualified and prepared to effectively lead these groups. The researcher, who led the reminiscence groups, was a registered nurse with a nursing and nursing education background in both mental health and gerontological nursing. She had earned the degree Bachelor of Science in Nursing and was a candidate for the degree Master of Nursing. She had conducted a detailed investigation of group reminiscence therapy - its purposes, benefits, potential negative effects, group leadership and process. She had also previously participated in and led reminiscence therapy with individuals and groups.

The nurse who led the current events groups was a registered nurse with the degree Bachelor of Science in Nursing. She had had experience in nursing and nursing administration in gerontological

nursing. She had previously led current events groups with elderly patients. She also was a candidate for the degree Master of Nursing.

As planned previously, all data collected has been kept in a locked area in the researcher's home. As soon as the data was tabulated, the researcher "blacked out" subject names on the individual data collection forms to ensure anonymity and confidentiality for participants. Following successful defense of the thesis, the researcher has agreed to shred all of the data collected about each individual subject. The consent forms signed by each patient are to be retained for a period of no less than 5 years.

DATA ANALYSIS

Both descriptive and inferential statistics were used to analyze the collected data. Descriptive statistics such as mean values, standard deviations, ranges, or frequencies were used to summarize the data collected on the personal variables of subjects. No further analyses (e.g., inferential statistics) were done to test for any significant differences between groups on these personal variables because the groups appeared similar on the relevant variables. This analysis of personal variables was largely done by hand by the researcher. However, some computer analysis was done to support these findings (e.g., means, standard deviations, and frequencies of the entire sample as a whole for each personal variable).

As well as descriptive statistics used to summarize the data collected on both the dependent variables of self-esteem and depression, repeated measures analysis of variance and Scheffe tests were used to analyze this data. To test whether some of the more relevant personal variables could explain the different mean scores found on the dependent variables in the different groups, further analyses were done to test for any interactions of age, length of hospitalization stay, and levels of education.

A diary was kept by the researcher throughout the study. This diary was used to record information about the progress within groups, any significant events or procedures related to the conduct of the study, and any significant historical events occurring in the general lives of the subjects in the study. It was felt by the researcher that these types of data could add insight to the interpretation of the collected data and to the conclusions which might be drawn from the study.

CHAPTER FOUR

RESULTS, DISCUSSION & INTERPRETATION

Introduction

To test the two hypotheses in this study, all data collected on the personal and dependent variables were entered into an MTS (Michigan Terminal System) file. The data was analyzed using the SPSSx software program on an AMDAHL mainframe computer. MANOVA, a generalized multivariate analysis of variance and covariance program, was used because this program could perform univariate and multivariate linear estimations and tests of hypotheses for any crossed or nested designs either with or without covariates, and can specify interaction effects between factors (SPSSx user's guide, 1986).

For this study, MANOVA was used first to perform analysis of variance (ANOVA) using a repeated measures design (pre-test, post-test) to determine if there were significant differences among group means on both of the dependent variables of depression and self-esteem. Then, because the results of the ANOVA indicated that there were significant differences among group means, Scheffe tests were done to make comparisons or contrasts among all possible pairs of means, both within and between treatment groups. This later procedure was necessary in order to determine which group means were significantly different. ANOVA was thought to be an appropriate test because ANOVA tests the hypothesis that at least two population means in a set are not equal. Two way ANOVA was

the procedure used to determine the effects of the treatments (group membership) and time (pre- to post-test time period) on the dependent variables of depression and self-esteem, as well as to investigate interaction between the two factors of treatment (group) and time. Scheffe tests were carried out in this study because this procedure is thought to be one of the most conservative multiple comparison procedures which allows for comparisons or contrasts of all possible combinations of group means to determine which differ and which do not (Volicer, 1984, p. 211).

The results related to the following two hypotheses are presented:

1. elderly patients receiving group reminiscence therapy will demonstrate significantly greater decreases in depression (after the treatment period) than participants in both of the other treatment conditions; and,
2. elderly patients receiving group reminiscence therapy will demonstrate significantly greater increases in self-esteem (after the treatment period) than participants in both of the other treatment groups.

The results and the discussion of the results for each of the two dependent variables of depression and self-esteem are presented separately. For each dependent variable, the following categories of results are discussed: descriptive statistical results describing the pre-test and post-test mean scores and ranges, ANOVA results investigating whether there were any significant

differences among group means, Scheffe tests comparing or contrasting all the possible group means to determine which means differed significantly, and additional ANOVA results investigating whether there were any differences in the mean treatment group scores when the factors of age, length of hospital stay, or years of education were considered. This chapter concludes with a discussion of the interpretation of the results.

DEPRESSION

Descriptive Statistical Results

Table 4.1, below, summarizes the descriptive statistical results found for each group on the dependent variable of depression. The mean group score at both the pre-test and post-test times, the standard deviation for that group mean score, the number of subjects in the group, and the range of scores within the group are presented. These descriptive results are presented separately for the entire sample as a whole (all sample), the reminiscence group, the current events group, and the no intervention group.

Table 4.2, below, summarizes the mean group scores found on depression (measured by the GDS) at both the pre-test and post-test times. Figure 1, below, is a graphic presentation of these group mean perfomances on the GDS at both the pre-test and post-test times.

From Table 4.2 and Figure 1, trends in the means within groups for the variable depression can be seen. The following trends were found from the pre-test to the post-test time periods. Reminiscence group participants demonstrated a mean decrease of

Table 4.1

DEPRESSION: Descriptive Statistical Results

DEPRESSION: GDS pre-test

group	mean	standard deviation	number	range
all sample	12.87	5.32	37	5-25
reminiscence	14.08	4.96	13	7-25
current events	12.75	4.97	12	5-22
no intervention	11.67	6.14	12	5-24

DEPRESSION: GDS post-test

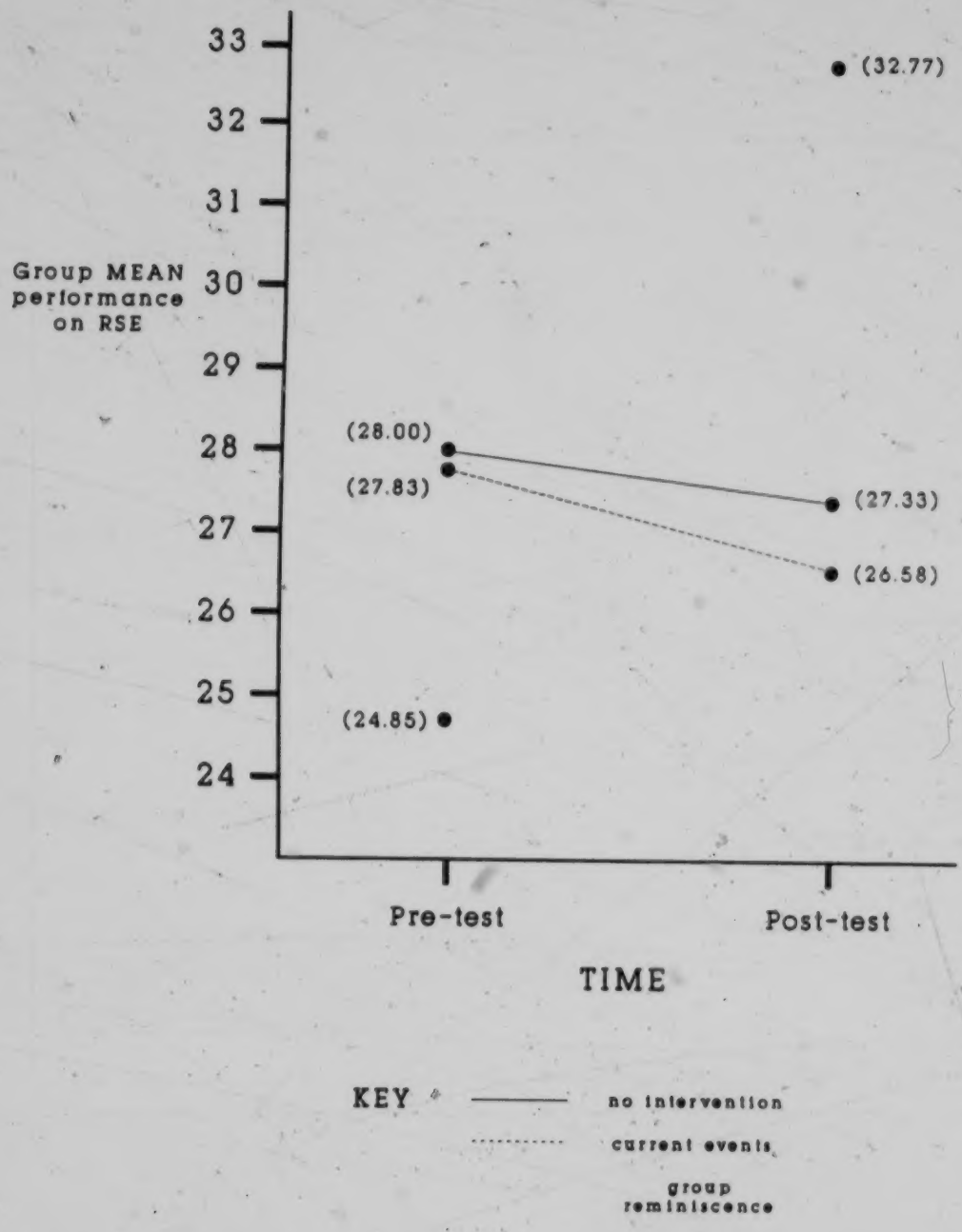
group	mean	standard deviation	number	range
all sample	11.95	6.36	37	0-29
reminiscence	8.39	6.22	13	0-20
current events	14.83	4.26	12	9-24
no intervention	12.92	7.24	12	4-29

Table 4.2

DEPRESSION: Mean Group Scores

group	pre-test	post-test	group mean/row mean
reminiscence	14.08	8.39	11.23
current events	12.75	14.83	13.79
no intervention	11.67	12.92	12.29
(column mean)	12.87	11.95	12.41 (grand mean)

Figure 2. Group mean self-esteem scores (pre-test to post-test)



5.69 on depression (GDS) scores from the pre-test to the post-test (pre-test mean = 14.08, post-test mean = 8.39). Averaging both pre-test and post-test scores together, the mean depression score for the reminiscence group was 11.23 (row mean). Current events group participants demonstrated a mean increase of 2.08 on depression scores from the pre-test to the post-test (pre-test = 12.75, post-test = 14.83). Averaging both the pre-test and post-test scores together, the mean depression score for the current events group was 13.79 (row mean). The no intervention group participants demonstrated a mean increase of 1.25 on depression scores from the pre-test to the post-test (pre-test = 11.67, post-test = 12.92). Averaging both the pre-test and post-test scores together, the mean depression score for the no intervention group was 12.29 (row mean). These trends in the within group means suggested that over the treatment period, group reminiscence participants experienced decreased levels of depression and, current events and no intervention group participants experienced increased levels of depression.

From Table 4.2 and Figure 1, the following trends between group means can also be observed: the small differences between pre-test GDS treatment group means, and the larger differences between post-test GDS treatment group means. These findings suggested that the three treatment groups were similar in pre-test GDS scores, but not similar in post-test GDS scores. This indicated that there may have been a differential effect of treatments between groups on the dependent variable of depression.

The mean score for all subjects on the GDS at the pre-test time was 12.87 and at the post-test time was 11.94 (column means). This mean decrease in GDS scores of 0.93 from the pre-test to the post-test time suggested a slight overall decrease in depression for the entire sample taken together. The grand mean, or the mean of all subject scores from all groups at both pre- and post-test times, was 12.41.

The findings in Parsons (1986) supported the trends found in this study of decreased depression in subjects who received group reminiscence therapy. With a non-probability sample of nine elderly women, a significant mean decrease in depression (measured by the Geriatric Depression Scale) was found in participants after six weeks of group reminiscence therapy.

ANOVA Results

The results of the ANOVA carried out for the dependent variable of depression are summarized below in Table 4.3. ANOVA was used to test for significant differences in means on the variable of depression in relation to group, time (pre- to post-test), and interaction of group by time. The level of significance for hypothesis testing was established at 0.05.

First, ANOVA was used to investigate whether there was any significant group effect; whether there were significant differences in the treatment group means on the variable depression (row means in Table 4.2) of 11.23 for the reminiscence group, 13.79 for the current events group, and 12.29 for the no intervention group. The F-ratio found was 0.70 (d.f.= 2, 34), and the prob-

Table 4.3

DEPRESSION: ANOVA Results

ANOVA	F-ratio	DFH	DFE	critical-F	probability
group (row means)	0.70	2	34	3.29	0.50
time (column means)	3.24	1	34	4.20	0.08
group by time	23.89	2	34	3.29	< 0.01

ability was 0.50. There were no significant differences found between these three treatment group means (averaging both pre-test and post-test scores together) on the dependent variable of depression.

Second, ANOVA was used to investigate whether there was a time effect; whether there were significant differences in the mean GDS scores of all subjects from the pre-test (mean=12.87) to the post-test (mean=11.94) time period (column means from Table 4.2). The F-ratio found was 3.24 (d.f.= 1, 34), and the probability was 0.08. There were no significant differences found between the pre-test and the post-test GDS means, though significance was approached.

Third, ANOVA was used to investigate whether there was an interaction effect of group (treatment) and time. The F-ratio found was 23.89 (d.f.= 2, 34), and the probability was less than 0.01. Results indicated that there was interaction of group (treatment) with time, that there was a differential effect of the treatment as a function of time. Scheffe tests, discussed in the following section, were carried out to determine which groups differed significantly.

Contrasts of Specific Means

The relevant Scheffe tests for the dependent variable of depression are presented below in Table 4.4. The level of significance for hypothesis testing was established at 0.05. The Scheffe tests for the variable depression yielded only one significant difference between or within group means. There was a

Table 4.4

DEPRESSION: Contrasts/Multiple comparisons

comparison	req.dif.	obs.dif.	s.e.	d.f.	Scheffe
pre-reminiscence & pre-current events	7.90	1.33	2.26	39.54	3.50
pre-reminiscence & pre-no intervention	7.90	2.41	2.26	39.54	3.50
pre-current events & pre-no intervention	8.06	1.08	2.30	39.54	3.50
pre-reminiscence & post-reminiscence	3.04	5.69*	0.86	34.00	3.53
pre-current events & post-current events	3.17	2.08	0.90	34.00	3.53
pre-no intervention & post-no intervention	3.17	1.25	0.90	34.00	3.53

-"*" refers to a statistically significant difference

significant difference found between the pre-test and post-test mean GDS scores for the reminiscence group. The mean pre-test GDS score for the reminiscence group was 14.08 and the mean post-test GDS score was 8.39. Subjects in the reminiscence group demonstrated a mean decrease in depression scores of 5.69 from the pre-test to the post-test time period. The required difference for the Scheffe test to yield a significant difference was 3.04 (Scheffe=3.53, d.f.=1, 34). This finding of a significant difference between the mean GDS pre-test and post-test scores for the reminiscence group supported the first hypothesis in this study. This hypothesis proposed that the subject patients receiving group reminiscence therapy would demonstrate significantly greater decreases in depression, over the treatment period, than subjects in the other two treatment groups. Further support for this hypothesis was that no significant differences were found between the pre-test and post-test GDS mean scores for either of the other two treatment groups (both being control groups). These findings suggested that the treatment of group reminiscence therapy caused the difference found between the mean performance of reminiscence group subjects on the GDS at the pre-test time compared to the mean group performance at the post-test time.

Findings of Parsons (1986) also supported the Scheffe test findings of a significant decrease in the pre-test to the post-test depression scores for the subjects who received group reminiscence therapy. Using a paired t-test to analyze

differences between mean pre-test and post-test depression scores, Parsons found a significant mean decrease in depression scores for the nine elderly women who participated in group reminiscence therapy for six weeks.

However, findings of Perotta & Meacham (1981) did not support findings in this study. In a non-probability sample of 21 elderly persons who were randomly assigned to one of the three treatment groups of individual reminiscence therapy, current life events discussion, or no intervention, Perotta & Meacham found no significant differences between the mean pre-test and post-test depression scores for any of the treatment groups. It is important to note that the type of reminiscence therapy used in the Perotta & Meacham study was individual, and not the group reminiscence therapy which was used in this study. It is likely that the results of both studies were not similar because the treatment conditions were not the same.

The Scheffe tests investigating differences among the three treatment group means on the pre-test depression (GDS) scores did not yield any significant differences, nor did any of the observed differences between the pre-test treatment group mean GDS scores approach the required difference to indicate a significant difference. This finding of no significant differences among the three treatment groups at the pre-test time on the variable of depression has provided further evidence of the equivalence of the three treatment groups before implementation of the treatment.

Additional Analyses Using ANOVA

Additional ANOVA analyses were carried out to test whether age, length of hospital stay, or years of education could account for any differences of the group mean scores on the dependent variable of depression. Each of these personal variables was added as a factor in the ANOVA. The variable "age" was recoded as low and high; low being 60-78 years and high being 79-98 years. The variable "length of hospital stay" was recoded as low and high; low being 0.17-4 years and high being 4.0001-16 years. The variable "years of education" was recoded as low and high; low being 3-8.99 years and high being 9-16 years. ANOVA was used to test whether any dependent variable group means differed significantly for low and high age, low and high years of hospital stay, and low and high years of education. The level of significance for hypothesis testing was established at 0.05.

The results are presented below in Table 4.5. No significant differences were found among means by age, length of hospital stay, or years of education. Nor was there any 2-way or 3-way interaction among treatment groups and age, length of hospital stay, and years of education for the dependent variable of depression. These findings were suggestive that the previously discussed significant differences in the treatment group means on the dependent variable of depression were not explained by the subjects' age, years of education, or length of hospital stay. Further support was provided for the first hypothesis in this study, suggesting that it was the treatment of group reminiscence therapy which caused the

Table 4.5

DEPRESSION: Additional ANOVA Results

anova	F-ratio	DFH	DFE	critical-F	probability
age (low & high)	0.87	1	31	4.16	0.36
group by age	2.84	2	31	3.31	0.07
age by time	0.15	1	31	4.16	0.70
group by age by time	0.56	2	31	3.31	0.58
length of hospital stay (low & high)	0.01	1	31	4.16	0.92
group by stay	0.56	2	31	3.31	0.58
stay by time	1.76	1	31	4.16	0.19
group by stay by time	0.93	2	31	3.31	0.41
education (low & high)	0.44	1	31	4.16	0.51
group by education	1.54	2	31	3.31	0.23
education by time	3.04	1	31	4.16	0.09
group by education by time	0.14	2	31	3.31	0.87

significant mean decrease in depression in the group reminiscence therapy subjects.

SELF-ESTEEM

Descriptive Statistical Results

Table 4.6, below, summarizes the descriptive statistical results found for each group on the dependent variable of self-esteem. The mean group score at both the pre-test and post-test times, the standard deviation for that group mean score, the number of subjects in the group, and the range of scores within the group are presented. These descriptive results are presented separately for the entire sample as a whole (all sample), the reminiscence group, the current events group, and the no intervention group.

Table 4.7, below, summarizes the mean group scores found on self-esteem (measured by the RSE) at both the pre-test and the post-test times. Figure 2, below, is a graphic presentation of the group mean performances on the RSE at both the pre-test and the post-test times.

From Table 4.7 and Figure 2, trends in the means within groups on the variable self-esteem can be observed. The following trends were found from the pre-test to the post-test time periods. Reminiscence group participants demonstrated a mean increase of 7.92 on self-esteem (RSE) scores from the pre-test to the post-test (pre-test mean = 24.85, post-test mean = 32.77). Averaging the pre-test and post-test scores together, the mean self-esteem score for the reminiscence group was 28.81 (row mean). Current events group participants demonstrated a mean decrease of 1.25 on self-esteem scores from the pre-test to the post-test (pre-test = 27.83,

Table 4.6

SELF-ESTEEM: Descriptive Results

SELF-ESTEEM: RSE pre-test

group	mean	standard deviation	number	range
all sample	26.84	3.78	37	19-35
reminiscence	24.85	2.58	13	21-30
current events	27.83	3.56	12	19-31
no intervention	28.00	4.43	12	20-35

SELF-ESTEEM: RSE post-test

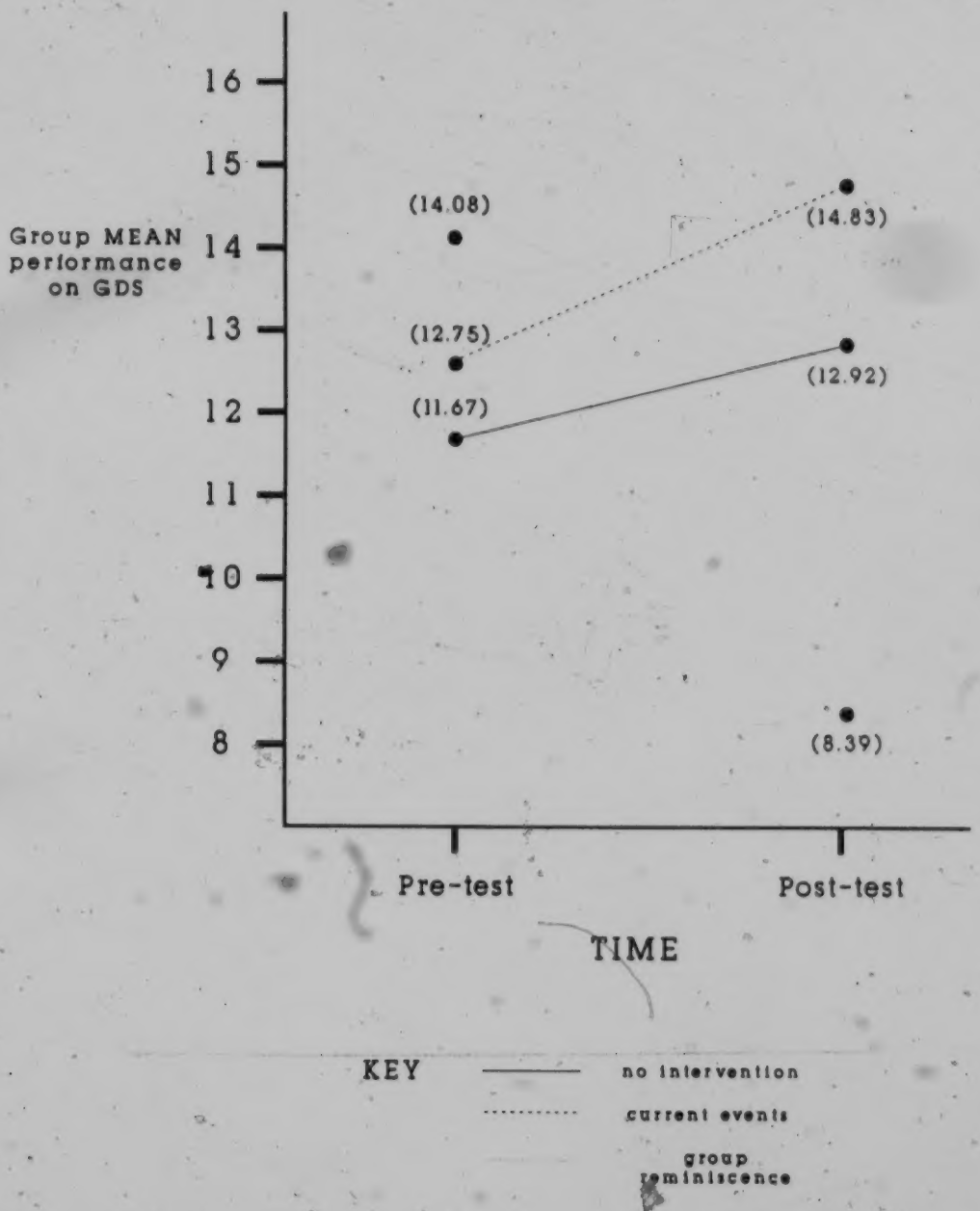
group	mean	standard deviation	number	range
all sample	29.00	5.01	37	18-39
reminiscence	32.77	3.00	13	27-39
current events	26.58	4.96	12	18-35
no intervention	27.33	4.62	12	20-38

Table 4.7

SELF-ESTEEM: Mean Group Scores

group	pre-test	post-test	group mean/row mean
reminiscence	24.85	32.77	28.81
current events	27.83	26.58	27.21
no intervention	28.00	27.33	27.67
(column mean)	26.84	29.00	27.92 (grand mean)

Figure 1. Group mean depression scores (pre-test to post-test)



post-test = 26.58). Averaging the pre-test and post-test scores together, the mean self-esteem score for the current events group was 27.21 (row mean). The no intervention group demonstrated a mean decrease of 0.67 from the pre-test to the post-test (pre-test = 28.00, post-test = 27.33). Averaging the pre-test and the post-test scores together, the mean self-esteem score for the no intervention group was 27.67 (row mean). These trends in the within group means (pre-test to post-test) suggested that over the treatment period, group reminiscence participants experienced increased levels of self-esteem, and current events and no intervention group participants experienced decreased levels of self-esteem.

From Table 4.7 and Figure 2, the following trends between group means can also be observed: the small differences between pre-test RSE treatment group means, and the larger differences between post-test RSE treatment group means. These findings suggested that the three treatment groups were similar in pre-test RSE scores, but not similar in post-test RSE scores. This indicated that there may have been a differential effect of treatments between groups on the dependent variable of self-esteem.

The mean score on the RSE at the pre-test time for all subjects was 26.84 and at the post-test time was 29.00 (column means). This mean increase in RSE scores of 2.16 from the pre-test to the post-test time suggested an overall average increase in

self-esteem for the entire sample taken together. The grand mean for all RSE scores was 27.92.

The findings of Lappe (1987) supported the trend found in this study of increased self-esteem in subjects who received group reminiscence therapy. With a non-probability sample of 83 elderly subjects who were randomly assigned to either a group reminiscence or current events group, a significantly greater increase in mean self-esteem scores (measured by the Rosenberg Self-Esteem Scale) was found from pre-test to post-test time in the reminiscence group subjects. As well, contrary to the findings of this study, Lappe found that the current events treatment group which met once weekly also demonstrated a significant increase in mean levels of self-esteem from the pre-test to the post-test time period. However, the current events treatment group which met twice weekly in the Lappe study, demonstrated a non-significant decrease in mean self-esteem over the treatment period. This last trend is similar to the trend found in this study of a decrease in mean levels of self-esteem for the current events group from the pre-test to the post-test time period.

ANOVA Results

The results of the ANOVA carried out for the dependent variable of self-esteem are summarized below in Table 4.8. ANOVA was used to test for any significant differences on the variable of self-esteem in relation to group, time (pre- to post-test), and interaction of group by time. The level of significance for hypothesis testing was established at 0.05.

First, ANOVA was used to investigate whether there was a significant group effect; whether there were any significant differences in the treatment group means on the variable self-esteem (row means in Table 4.7) of 28.81 for the reminiscence group, 27.21 for the current events group, and 27.67 for the no intervention group. The F-ratio found was 0.62 (d.f.= 2, 34), and the probability was 0.54. There were no significant differences found between the treatment group means (averaging both pre-test and post-test scores together) on the dependent variable of self-esteem.

Second, ANOVA was used to investigate whether there was a time effect; whether there were any significant differences in the mean RSE scores of all subjects from the pre-test (mean=26.84) to the post-test (mean=29.00) time period (column means in Table 4.7). The F-ratio was 24.94 (d.f.= 1, 34), and the probability was less than 0.01. It was demonstrated that there was a significant difference between the "all sample" pre-test RSE and post-test RSE mean scores. The direction of this difference was a mean increase of 2.16, suggesting that there was a significant increase in self-esteem from the pre-test to the post-test time for the entire sample as a whole.

Third, ANOVA was used to test whether there was an interaction effect of group (treatment) and time. The F-ratio found was 48.09 (d.f.= 2, 34), and the probability was less than 0.01. Results indicated that there was an interaction of group (treatment) with time, that there was a differential effect of the treatment as a

Table 4.8

SELF-ESTEEM: ANOVA Results

ANOVA	F-ratio	DFH	DFE	critical-F	probability
group (row means)	0.62	2	34	3.29	0.54
time (column means)	24.94	1	34	4.20	< 0.01
group by time	48.09	2	34	3.29	< 0.01

function of time. Scheffe tests, discussed next, were carried out to determine which groups differed significantly.

Contrasts of Specific Means

The relevant Scheffe tests results for the dependent variable of self-esteem are presented below in Table 4.9. The level of significance for hypothesis testing was established at 0.05. A significant difference was found between the mean pre-test and post-test RSE scores for the reminiscence group. The mean pre-test RSE score for the reminiscence group was 24.85 and the mean post-test RSE score was 32.77. Subjects in the reminiscence group demonstrated a mean increase in self-esteem scores of 7.92 from the pre-test to the post-test time period. The required difference for the Scheffe test to yield this significant difference was 2.58 (Scheffe=3.53, d.f.=1, 34). This finding of a significant difference between the mean RSE pre-test and post-test scores for the reminiscence group subjects supported the second hypothesis in this study. This hypothesis proposed that the subjects receiving group reminiscence therapy would demonstrate significantly greater increases in levels of self-esteem, over the treatment period, than subjects in either of the other two treatment groups. Further support for this hypothesis was provided by the finding of no significant differences between the pre-test and post-test RSE mean scores for either of the other two treatment groups (both being control groups). Both the current events group and the no intervention group demonstrated non-significant decreases in mean

Table 4.9

SELF-ESTEEM: Contrasts/Multiple Comparisons

comparison	req.dif.	obs.dif.	s.e.	d.f.	Scheffe
pre-reminiscence & pre-current events	5.49	2.99	1.57	42.47	3.49
pre-reminiscence & pre-no intervention	5.49	3.15	1.57	42.47	3.49
pre-current events & pre-no intervention	5.60	0.17	1.60	42.47	3.49
pre-reminiscence & post-reminiscence	2.58	7.92*	0.73	34.00	3.53
pre-current events & post-current events	2.68	1.25	0.76	34.00	3.53
pre-no intervention & post-no intervention	2.68	0.67	0.76	34.00	3.53

-"*" refers to a statistically significant difference

RSE scores from the pre-test to the post-test time period. These findings were suggestive that the treatment of group reminiscence therapy caused the difference found between the mean performance of reminiscence group subjects on the RSE at the pre-test time compared to the mean group perfomance at the post-test time.

The findings of Lappe (1987) supported the Scheffe test finding in this study of a significant mean increase in the pre-test to the post-test scores for subjects who received group reminiscence therapy. Using a repeated measures analysis of variance, Lappe found a significantly greater increase in the mean self-esteem scores (measured by the RSE) from the pre-test to the post-test time period for group reminiscence therapy subjects than for the current events group subjects. However, contrary to the findings in this study, Lappe also found a significant mean increase in self-esteem from the pre-test to the post-test time period in subjects who participated in the current events group once weekly. In the Lappe study, subjects who participated in the current events group twice weekly demonstrated a non-significant mean decrease in self-esteem from the pre-test to the post-test time period. This second trend in the Lappe study was similar to the findings in this study of the differences in RSE pre-test to post-test scores in the current events and no intervention groups.

The findings of Perotta & Meacham (1981) were not consistent with findings in this study. Perotta & Meacham found no significant differences between the mean pre-test and post-test self-esteem scores (measured by the RSE) for any of the three

treatment groups. Again, it is important to note that the type of reminiscence therapy used in the Perotta & Meacham study was individual reminiscence therapy, and not group reminiscence therapy, which was used in this study. Therefore, the different results found in both these studies likely reflected the effects of different treatment conditions rather than reflected conflicting results.

The Scheffe tests which investigated differences among the three treatment group RSE means at the pre-test time period did not yield any significant differences, nor did any of the observed differences between treatment group mean pre-test RSE scores approach the required difference needed to indicate a significant difference. This finding of no significant differences among the three treatment groups at the pre-test time on the variable of self-esteem has provided further evidence of the equivalence of the three treatment groups before implementation of the treatment.

Additional Analyses Using ANOVA

Additional ANOVA analyses were carried out to test whether age, length of hospital stay, or years of education could account for any differences of the group mean scores on the dependent variable of self-esteem. Each of these personal variables was added as a factor in the ANOVA. The variable "age" was recoded as low and high; low being 60-78 years and high being 79-98 years. The variable "length of hospital stay" was recoded as low and high; low being 0.17-4 years and high being 4.0001-16 years. The variable "years of education" was recoded as low and high; low

being 3-8.99 years and high being 9-16 years. ANOVA was used to test whether any group means differed significantly for low and high age, low and high years of hospital stay, and low and high years of education. The level of significance for hypothesis testing was established at 0.05.

The results are presented below in Table 4.10. No significant differences were found among means by age, length of hospital stay, or years of education. Nor was there any 2-way or 3-way interaction among treatment groups and age, length of hospital stay, and years of education for the dependent variable of self-esteem. These findings were suggestive that the previously discussed significant differences in the treatment group means on the dependent variable of self-esteem were not explained by the subjects' age, years of education, or length of hospital stay. Further support was provided for the second hypothesis in this study, suggesting that it was the treatment of group reminiscence therapy which caused the significant mean increase in self-esteem in the group reminiscence therapy subjects.

Summary of the Results

The following is a summary of the important findings in this study.

1. No significant mean differences were found among the three treatment groups on the pre-test depression scores.
2. No significant mean differences were found among the three treatment groups on the pre-test self-esteem scores.

Table 4.10

SELF-ESTEEM: Additional ANOVA Results

anova	F-ratio	DFH	DFE	critical-F	probability
age (low & high)	1.04	1	31	4.16	0.32
group by age	2.19	2	31	3.31	0.13
age by time	3.08	1	31	4.16	0.09
group by age by time	0.68	2	31	3.31	0.51
length of hospital stay (low & high)	0.24	1	31	4.16	0.63
group by stay	1.55	2	31	3.31	0.23
stay by time	0.29	1	31	4.16	0.59
group by stay by time	0.15	2	31	3.31	0.86
education (low & high)	0.19	1	31	4.16	0.67
group by education	0.21	2	31	3.31	0.81
education by time	0.61	1	31	4.16	0.44
group by education by time	0.46	2	31	3.31	0.64

3. A significant difference (-5.69) was found between the mean pre-test and post-test depression scores in the reminiscence group.
4. Non-significant trends of an increase in depression from the pre-test to the post-test time period were found in the current events and the no intervention groups.
5. A significant difference (+7.92) was found between the mean pre-test and post-test self-esteem scores in the reminiscence group.
6. Non-significant trends of a decrease in self-esteem from the pre-test to the post-test time period were found in the current events and the no intervention groups.
7. No significant differences were found within or between group mean scores on the dependent variables of depression and self-esteem when the subjects' age, years of education, and length of hospitalization were considered as factors.

Interpretation of the Findings

Findings of this study have stimulated the need to explore reasons why participation in group reminiscence therapy resulted in increased levels of self-esteem and decreased levels of depression. Several explanations are postulated to explain the findings. Elderly persons are confronted with a multitude of life changes to which they must adapt, either positively or negatively. These changes are frequently perceived and experienced by the elderly as losses. According to Erikson (1963), the developmental conflict for the elderly person in the final stage of life is to attain and maintain ego integrity (positive adaptation) or to experience

despair (negative adaptation). The elderly person is faced with the difficulty of resolving this conflict while also struggling to adapt to the changes and losses of later life. Consequently, elderly persons are particularly vulnerable to responding or adapting by experiencing feelings of despair, and thus negatively adapting to life events. Feelings of lowered self-esteem and depression are often the responses the elderly make while attempting to work through the crisis of later life and to adapt to life changes. However, the elderly need not respond with feelings of depression and lowered self-esteem if they can successfully adapt to these life changes and work toward experiencing ego integrity.

Findings of this study indicated that participants in group reminiscence therapy experienced increased levels of self-esteem and decreased levels of depression over the treatment period, and that participants in the current events and the no intervention groups did not. Because the no intervention group did not demonstrate increased levels of self-esteem and decreased levels of depression, it was concluded that the factor of passing of time could not explain the findings of increased self-esteem and decreased depression in reminiscence group participants. Both the treatment conditions of group reminiscence and current events discussion had some similar qualities. For example, both conditions involved interacting in a group of elderly patients and one nurse-therapist, group meetings were about one hour once weekly, "goodies" were shared during the group meetings, and all group participants were welcomed to each group meeting. However,

both treatment conditions were different in two respects. First, the nature of the topics or interactions were different for each group, and second, the groups were led by two different therapists. Both therapists had similar qualifications and even similar past professional backgrounds. Their manners of interacting with patients were also similar, both being warm and sincere. Thus, it was not likely that the effects of the presence of the nurse-therapist accounted for the differences found between groups in the levels of depression and self-esteem over the treatment period. Instead, it was more likely that the nature of the treatment or interactions in the reminiscence group accounted for the differences found.

Participants in the current events discussion group were encouraged to discuss present life events and situations. The current events topics may or may not have been important to the elderly person. The goal of the group was simply to gain information within a group setting and not necessarily to find any significant meaning in the event discussed. In group reminiscence therapy, participants were encouraged to discuss their past experiences and examine how these experiences had affected their lives, both in the past and in the present. If the experience was positive in nature, the recall and examination of the experience seemed to facilitate the elderly person to identify or reaffirm some positive attribute to themselves. They derived a sense of pride and pleasure from the reminiscence. If the past experience was negative in nature, the recall and examination of the

experience seemed to allow the person to make sense of the event as it was then, but more importantly, it helped them to discover that no matter what had transpired, they had still survived. The elderly people in this group attempted to achieve a sense of balance between the negative nature of the past experience with a positive outcome - having survived. In reminiscences of a negative nature, participants worked toward arriving at a comfortable perspective of the past experience and its present meaning. The ability to have "survived" was a common important theme in the reminiscence group. Group members often supported each other by saying statements such as "That must have been so difficult for you, but look how strong it made you - you survived!" Reminiscence group participants seemed to be attempting to gain and maintain ego integrity or acceptance of the life lived, for both the positive and negative aspects of the life lived.

Facilitating the older person to reminisce was only part of the strength of the treatment. Probably equally as valuable, was the support and acceptance that the group provided for each member. No matter what the nature of the reminiscence was, the group (after the third week) spontaneously and consistently expressed their acceptance by consoling, praising, or just attending to the reminiscer. The strength and frequency of positive reinforcement given and received by group participants was possibly a very important factor in explaining the results obtained in this study. Being part of a group which shared important and private memories seemed to have had a powerful effect. Participants seemed to

experience a feeling of belonging in this group and a feeling of being unconditionally and freely cared for by the group. This was evidenced by participants referring to the group as "our group", by asking about the whereabouts and condition of absent members, by calling each other by name, by talking to each other in and out of the group, and by looking and smiling at each other. This sense of belonging seemed to encourage the person to perceive a sense of self-worth or self-esteem.

Related to the positive effects of belonging to a group which cared for them, was the effect of decreased isolation that seemed to occur because of the experience of sharing similar memories. Common memories of experiences and feelings seemed to bring group members close together and help them feel less isolated from each other, and possibly from the world in general. Decreased isolation may have helped participants experience decreased feelings of sadness, despair, and depression.

In conclusion, three aspects of the treatment of group reminiscence therapy were examined to tentatively explain the findings of decreasd depression and increased self-esteem in group reminiscence therapy participants. First, the nature of the treatment of reminiscence seemed to assist the elderly person to attain and maintain a sense of acceptance of the life lived. Second, the support and acceptance provided by group members to each other seemed to help group members develop a sense of belonging to the group. Third, the sharing of important similar memories seemed to decrease the sense of isolation that the

elderly may have felt. It was likely that through group reminiscence therapy, these elderly patients demonstrated decreased levels of depression and increased levels self-esteem because they were assisted to work toward accepting the life lived, to experience a sense of belonging and being cared for by a group of peers, and to experience the opportunity to become less isolated from others.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The objective of this study was to investigate the effectiveness of group reminiscence therapy as a nursing intervention. This study focused on the effects that group reminiscence therapy had on subjects' levels of depression and self-esteem. Both hypotheses were supported. Subjects (elderly patients) who received the treatment of group reminiscence therapy demonstrated significant decreases in depression and significant increases in self-esteem from the pre-test to the post-test time period. The subjects in the two other treatment groups, the control groups of current events and no intervention, did not demonstrate these significant changes in depression and self-esteem over the same treatment period. In fact, subjects in both of these control groups demonstrated similar non-significant trends of an increase in depression and a decrease in self-esteem over the treatment period. These findings supported the hypotheses that it was the experience of group reminiscence therapy that precipitated the increased levels of self-esteem and decreased levels of depression in the reminiscence group participants, and not simply the experience of participating in a group. The results of the additional ANOVA tests, which were done to investigate whether differences in subjects' age, level of education, or length of hospital stay could account for different group mean scores on both of the dependent

variables, suggested that none of these three variables explained the different mean scores found for the treatment groups on both of the two dependent variables.

Limitations of the Study

1. Though much effort was employed to strengthen the internal validity of the study through the design and by maintaining constancy in the research conditions (e.g., the environment, time, data collector, communications with subjects, and the treatment conditions), threats to the internal validity of the study may have existed.

2. Because of the non-probability sampling method used in this study, caution should be employed when attemping to make generalizations to a larger population of which this sample may not be representative.

3. As well as the sampling method used, there may have been other threats to the external validity of this study. First, the "Hawthorne effect", or the knowledge of being included in a study, may have obscured the effects of the treatments on the dependent variables of depression and self-esteem. Subjects may have changed their behavior because of their participation in the study. If such an effect occurred in this study, it is likely that the effects would have existed across the three treatment groups in a similar manner because all subjects knew that they were participating in a study. The second threat, and perhaps the more serious threat, was related to possible experimenter effects. The researcher completed all of the sampling procedures, all of the

pre-testing of each subject on each dependent variable, and all of the post-testing of each subject. The researcher also delivered the group reminiscence therapy to all subjects in the reminiscence group. Because the researcher was closely attached to the subjects in the reminiscence group, it was possible that the post-test performance of subjects in the reminiscence group was affected by the very presence of the researcher at the post-test time.

Implications for Nursing

The findings in this study have implications for nursing practice, nursing administration, and nursing education. In nursing practice, nurses care for elderly patients who often have lowered self-esteem and increased depression. The intervention of group reminiscence therapy appeared to significantly increase the levels of self-esteem and significantly decrease the levels of depression in the elderly patients. By assisting elderly patients to reminisce about their past experiences and the past experiences of others within groups, and by helping the elderly interact with others about these experiences, the nurse may help the elderly patient have feelings of increased self-esteem and decreased depression.

Nurses often provide nursing care by teaching others to perform interventions which are intended to promote specific patient goals. Therefore, a second implication of the findings of this study for nursing practice is that of the possible benefits of teaching the significant others of elderly patients about the purposes and potential benefits of engaging in group reminiscence therapy with

elderly patients. Elderly patients may benefit from engaging in group reminiscence with persons other than co-residents or the institutional nursing and support staff. Thus, it may be appropriate to encourage the significant others of elderly patients (e.g., family) to engage in life review with the elderly. Significant others may need to know about the purposes and benefits of group reminiscence, as well as needing guidance about conditions to be considered to facilitate group reminiscence and its potential benefits.

The findings of this study may also have implications for nursing administration. Nursing administrators are often the group of individuals who make decisions concerning the allocation of resources (e.g., personnel, programs, etc.). The findings of this study suggested that not all types of patient group programs yield the same benefits to the elderly patient. Decisions about which groups should be supported in an agency can be made by matching the patient goals with the intervention demonstrated most effective in meeting these goals. The results of this study suggested that group reminiscence therapy was an effective intervention to help elderly patients reach the goals of decreased depression and increased self-esteem.

The findings of this study may also have implications for nursing education. When teaching nursing students about caring for elderly patients who have, or have the potential for, lowered self-esteem or increased depression, the findings of this study may be used as evidence of the possible effectiveness of group reminis-

cence therapy as a nursing intervention which promotes increased self-esteem and decreased depression in elderly patients.

Recommendations for Study

There is need for further investigation about the effectiveness of group reminiscence therapy as a nursing intervention. First, replication studies are needed to confirm the results of this study in terms of the effects of group reminiscence on the levels of depression and self-esteem in elderly patients. Second, because it is not known how to optimally prolong or maintain the effects of increased self-esteem and decreased depression with group reminiscence therapy, investigation is needed to determine which frequency (e.g., once weekly for a period of time only, or once weekly and continuously) would best promote and maintain the effects of increased self-esteem and decreased depression.

Third, further investigation is needed to compare the effects of group reminiscence and individual reminiscence therapies. Though both of these types of therapies have been considered to be similar, there is no evidence to substantiate this assumption. Further investigation is needed using similar program protocols about the effects of both modes of reminiscence therapy so that nurses may make more informed decisions as to which therapy will best meet patient goals.

Fourth, the effectiveness of group reminiscence therapy with different kinds of elderly patients should be investigated (e.g., the cognitively impaired elderly patient). Because of the caution

advised in generalizing these results to other populations, further evidence is needed about the effectiveness of group reminiscence therapy with different kinds of elderly patients. Related to this is the need to study the effectiveness of group reminiscence therapy with patients other than just the elderly. Other patient groups who are experiencing losses (e.g., the dying patient) may also be experiencing lowered self-esteem and increased depression. These patient populations may also potentially benefit from engaging in the intervention of group reminiscence therapy.

The last recommendation for further study is the suggestion for the need to investigate other potential benefits which patients may experience when engaging in the intervention of group reminiscence therapy. This intervention may also be effective in diminishing other patient problems such as decreased ability to interact with others, powerlessness, loneliness, or role failure. Further study is needed to explore other potential benefits of group reminiscence therapy.

Summary

Nurses frequently care for elderly patients who experience lowered self-esteem and increased depression, yet, little evidence has existed to help nurses make informed decisions about the choice of nursing interventions to help alleviate these patient problems. The objective of this study was to investigate the effectiveness of group reminiscence therapy as a nursing intervention, specifically, to measure the effect of group reminiscence therapy on the levels of depression and self-esteem in elderly patients.

An experimental design involving the three treatment groups of group reminiscence therapy, current events discussion group, and no intervention was used in this study. Thirty-seven elderly patients from an extended care center agreed to participate in the study. Each subject was tested on the dependent variables of depression and self-esteem before the treatment conditions were implemented (pre-test) and after the treatment conditions were finished (post-test). The treatment period was eight weeks in length. The Geriatric Depression Scale was used to measure subject levels of depression, and the Rosenberg Self-Esteem Scale was used to measure subject levels of self-esteem.

The findings in this study supported the two hypotheses. Subjects in the reminiscence group demonstrated a significant decrease in levels of depression and a significant increase in levels of self-esteem over the treatment period. Subjects in the other two groups did not demonstrate any significant changes in levels of depression or self-esteem over the treatment period. These findings suggested that group reminiscence therapy was an effective nursing intervention which promoted increased self-esteem and decreased depression in elderly patients.

Because of the sampling method used and possible experimenter effects, a limitation of this study relates to its external validity. Implications for nursing practice, nursing administration, and nursing education were discussed. Recommendations, such as the need for replication studies, the need to investigate how to maintain or prolong the effects of group reminiscence therapy, the

need to compare the effects of individual and group reminiscence therapy, the need to investigate the effects of group reminiscence therapy with different types of patients, and the need to investigate about other potential benefits of group reminiscence therapy were also discussed.

REFERENCES

Baker, N.J. (1985). Reminiscing in group therapy for self-worth. Journal of Gerontological Nursing, 11(7), 21-24.

Beaton, S.R. (1980). Reminiscence in old age. Nursing Forum, 19(3), 270-283.

Boylin, W., Gordon, S.K., & Nehrke, M.F. (1976). Reminiscing and ego integrity in institutionalized elderly males. The Gerontologist, 16(2), 118-124.

Bramwell, L. (1984). Use of the life review history in pattern identification and health promotion. Advances in Nursing Science, 1(1), 37-44.

Brink, T.L., Yesavage, J.A., Lum, O., Heersema, P.H., Adey, M., & Rose, T.L. (1982). Screening tests for geriatric depression. Clinical Gerontologist 1(1), 37-43.

Burnside, I.M. (1976). Overview of group work with the aged. Journal of Gerontological Nursing, 2(6), 14-17.

Butler, R.N. (1963). The life review: An interpretation of reminiscence in the aged. Psychiatry, 26, 65-76.

Butler, R.N. (1974). Successful aging and the role of the life review. Journal of the American Geriatrics Society, 22(12), 529-535.

Butler, R.N. (1975). Psychiatry and the elderly: An overview. The American Journal of Psychiatry, 132(9), 893-900.

Carpenito, L.J. (1987). Nursing diagnosis: Application to clinical practice. Philadelphia: Lippincott.

Cresswell, D.L., & Lanyon, R.I. (1981). Validation of a screening battery for psychogeriatric assessment. Journal of Gerontology, 36, 435-440.

Ebersole, P.P. (1976). Problems of group reminiscencing with the institutionalized aged. Journal of Gerontological Nursing, 2(6), 23-27.

Ebersole, P.P. (1978). Establishing reminiscence groups. In I.M. Burnside (Ed.), Working with the elderly: Group process and techniques (pp. 236-254). North Scituate, MA: Duxbury Press.

Ebersole, P.P. (1985). Toward healthy aging: Human needs and nursing response. St. Louis: Mosby.

Ellison, K.B. (1981). Working with the elderly in a life review group. Journal of Gerontological Nursing, 7(9), 537-541.

Erikson, E.H. (1963). Childhood and society. New York: W.W. Norton.

Ethical guidelines for nursing research involving human subjects. (1983). Ottawa: Canadian Nurses Association.

Green, B.L., Wehling, C., & Talsky, G.J. (1987). Group art therapy as an adjunct to treatment for chronic outpatients. Hospital and Community Psychiatry, 38(9), 988-991.

Hala, M.P. (1975). Reminiscence group therapy project. Journal of Gerontological Nursing, 1(3), 34-41.

Haight, B.K., & Bahr, R.T. (1984). The therapeutic role of life review in the elderly. Academic Psychology Bulletin, 6(3), 287-299.

Hamilton, D.B. (1985). Reminiscence therapy. In G.M. Bulechek & J.C. McCloskey (Eds.), Nursing interventions: Treatments for nursing diagnoses (pp. 139-151). Philadelphia: Saunders.

Hamilton, M. (1960). A rating scale for depression. Journal of Neurological and Neurosurgical Psychiatry, 23, 56-62.

Havighurst, R.J., & Glasser, R. (1972). An exploratory study of reminiscence. Journal of Gerontology, 27(2), 245-253.

Herst, L., & Moulton, P. (1985). Psychiatry in the nursing home. Psychiatric Clinics of North America, 8(3), 551-561.

Kahn, R.L., Goldfarb, A.I., Pollack, M., & Peck, A. (1960). Brief objective measures for determination of mental status in the aged. American Journal of Psychiatry, 117, 326-328.

King, K.S. (1982). Reminiscing psychotherapy with aging people. Journal of Psychosocial Nursing and Mental Health Services, 20(2), 21-25.

Lappe, J.M. (1987). Reminiscing: The life review therapy. Journal of Gerontological Nursing, 13(4), 12-16.

Leszcz, M., Feigenbaum, E., Sadavoy, J., & Robinson, A. (1985). A men's group: Psychotherapy of elderly men. International Journal of Group Psychotherapy, 35(2), 177-196.

Lewis, C.N. (1971). Reminiscing and self-concept in old age. Journal of Gerontology, 26(2), 240-243.

Lewis, M.I., & Butler, R.N. (1974). Life review therapy: Putting memories to work in individual and group psychotherapy. Geriatrics, 29, 165-173.

MacRae, I. (1982). Growth and development for elders: Reminiscence, an underused nursing resource. Nursing Papers, 14(1), 48-54.

Mangen, D.J., & Peterson, W.A. (1984). Research instruments in social gerontology. Minneapolis, MN: University of Minnesota Press.

Matteson, M., & Munsat, E.M. (1982). Group reminiscence therapy with elderly clients. Issues in Mental Health Nursing, 4(3), 177-189.

McMahon, A.W., & Rhudick, P.J. (1964). Reminiscing: Adaptional significance in the aged. Archives of General Psychiatry, 10(3), 292-298.

McMordie, W.R., & Blom, S. (1979). Life review therapy: Psychotherapy for the elderly. Perspectives in Psychiatric Care, 17(4), 162-166.

Molinari, V., & Reichlin, R.E. (1984-85). Life review reminiscence in the elderly: A review of the literature. The International Journal of Aging and Human Development, 20(2), 81-92.

Mosby's medical and nursing dictionary. (1983). St. Louis: Mosby.

Parsons, C.L. (1986). Group reminiscence therapy and levels of depression in the elderly. Nurse Practitioner, 11(3), 68, 70, 75-76.

Perotta, P., & Meacham, P.A. (1981-82). Can a reminiscence intervention alter depression and self-esteem? The International Journal of Aging & Human Development, 14(1), 23-30.

Polit, D., & Hungler, B. (1983). Nursing research: Principles and methods. (2nd Ed.). Philadelphia: Lippincott.

Polit, D., & Hungler, B. (1985). Essentials of nursing research: Methods and application. Lippincott: Philadelphia.

Poulton, J.L., & Strassberg, D.S. (1986). The therapeutic use of reminiscence. International Journal of Group Psychotherapy, 36(3), 381-398.

Rosenberg, M. (1965). Society and the adolescent self-image. Princeton, NJ: Princeton University Press.

Rosenthal, T. (1982). Implementing reminiscent discussion groups. Virginia Nurse, Summer 1982, 57-60.

Roy, C. (1984). Introduction to nursing: An adaptation model. Englewood Cliffs, NJ: Prentice-Hall.

Sibler, E., & Tippett, J.S. (1965). Self-esteem: Clinical assessment and measurement validation. Psychological Reports, 16, 1017-1071.

Schnase, R.C. (1982). Therapeutic reminiscence in elderly patients. Journal of Nursing Care, 15(2), 15-17.

SPSSx user's guide. (1986). New York: McGraw-Hill.

Stuart, G.W., & Sundeen, J. (1983). Principles and practices of psychiatric nursing. St. Louis: Mosby.

Sullivan, C.A. (1983). Life review: A functional view of reminiscence. Physical and Occupational Therapy in Geriatrics, 2(1), 39-52.

Thornton, S., & Brotchie, J. (1987). Reminiscence: A critical review of the empirical literature. British Journal of Clinical Psychology, 26, 93-111.

University policy related to ethics in human research. (1985). Edmonton: University of Alberta.

Volicer, B.J. (1984). Multivariate statistics for nursing research. Orlando: Grune & Stratton.

Ward, R.A. (1977). The impact of subjective age and stigma on older persons. Journal of Gerontology, 32(2), 227-232.

Whalen, P. (1980). Tu solus (You alone): Alienation and resocialization of the elderly. Journal of Gerontological Nursing, 6(6), 348-353.

Whall, A.L. (1987). Self-esteem and the health of older adults. Journal of Gerontological Nursing, 13(4), 41-42.

Wilson, L., & Brass, W. (1973). Brief assessment of the mental state in geriatric domiciliary practice: The usefulness of the Mental Status Questionnaire. Age and Aging, 2, 92-101.

Yesavage, J.A., Brink, T.L., Rose, T.L., Lum, O., Huang, V., Adey, M., & Leirer, V.O. (1983). Development and validation of a geriatric depression screening scale: A preliminary report. Journal of Psychiatric Research, 17(1), 37-49.

Zung, W.W. (1965). A self-rating depression scale. Archives of General Psychiatry, 12, 63-70.

Appendix A

SUBJECT INFORMATION SHEET

Study: Group Reminiscence Therapy as a Nursing Intervention: An Experimental Study.

PARTICIPANT NAME: _____ **NUMBER:** _____
INSTITUTION: _____
AGE: _____ **SEX:** _____

HIGHEST LEVEL OF EDUCATION OBTAINED: _____

TYPE OF ROOM ACCOMMODATION:
_____ private
_____ semi-private
_____ ward (more than 2 beds)

SOCIAL CONTACTS:
Usual number of phone calls (made and received) per week _____
Usual number of visits from significant others per week _____
Usual number of outings per week _____

MARITAL STATUS:
_____ single
_____ married
_____ widowed
_____ divorced
_____ other

ADMISSION DATE: _____

Length of time residing in extended care center:
_____ years _____ months

Appendix B

THE MENTAL STATUS QUESTIONNAIRE

Following are ten questions. If the person accurately answers the question, a score of 1 is given for that question. The total score is summed and tabulated from a total of 10. Read each question carefully and allow the respondent time to answer. Jot down the respondents answer to allow for verification of scoring.

PATIENT NAME: _____ **NUMBER:** _____

Score

1. What is the name of this place? _____ ___
2. Where is it located? _____ ___
3. What day is today? _____ ___
4. What month is it now? _____ ___
5. What year is it now? _____ ___
6. How old are you? _____ ___
7. In what month were you born? _____ ___
8. In what year were you born? _____ ___
9. Who is the prime minister of Canada now? _____ ___
10. Who was the prime minister before him? _____ ___

_____

Total score _____

Date: _____ **Investigator:** _____

Appendix C

THE ROSENBERG SELF-ESTEEM SCALE

Please read each of the 10 statements carefully. Select the answer which best corresponds to how much you agree that the statement describes how you view or feel about yourself today. Mark an "X" over your answer. Please be as honest as you can be. For each statement you must choose one of the following responses to the statement: Strongly Agree, Agree, Disagree, Strongly Disagree.

PATIENT NAME: _____ **DATE:** _____ **NUMBER:** _____

1. **ON THE WHOLE, I AM SATISFIED WITH MYSELF.**

   STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

2. **AT TIMES I THINK I AM NO GOOD AT ALL.**

   STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

3. **I FEEL THAT I HAVE A NUMBER OF GOOD QUALITIES.**

   STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

4. **I AM ABLE TO DO THINGS AS WELL AS MOST OTHER PEOPLE.**

   STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

5. **I FEEL I DO NOT HAVE MUCH TO BE PROUD OF.**

   STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

6. **I CERTAINLY FEEL USELESS AT TIMES.**

   STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

7. **I FEEL THAT I AM A PERSON OF WORTH, AT LEAST ON AN EQUAL PLANE WITH OTHERS.**

   STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

8. **I WISH I COULD HAVE MORE RESPECT FOR MYSELF.**

   STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

9. **ALL IN ALL, I AM INCLINED TO FEEL THAT I AM A FAILURE.**

   STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

10. **I TAKE A POSITIVE ATTITUDE TOWARD MYSELF.**

    STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

Appendix D

GERIATRIC DEPRESSION SCALE

PLEASE CHOOSE THE BEST ANSWER - YES OR NO - FOR HOW YOU HAVE FELT OVER THE PAST WEEK. MAKE AN 'X' OVER YOUR ANSWER.

PATIENT NAME: _____ **DATE:** _____ **NUMBER:** _____

1. Are you basically satisfied with your life? .... YES or NO
2. Have you dropped many of your activities and interests? ..... YES or NO
3. Do you feel that your life is empty?..... YES or NO
4. Do you often get bored?..... YES or NO
5. Are you hopeful about the future?..... YES or NO
6. Are you bothered by thoughts you can't get out of your head?..... YES or NO
7. Are you in good spirits most of the time?..... YES or NO
8. Are you afraid that something bad is going to happen to you?..... YES or NO
9. Do you feel happy most of the time?..... YES or NO
10. Do you often feel helpless?..... YES or NO
11. Do you often get restless and fidgety?..... YES or NO
12. Do you prefer to stay at home, rather than going out and doing new things?..... YES or NO
13. Do you frequently worry about the future?..... YES or NO
14. Do you feel you have more problems with memory than most?..... YES or NO
15. Do you think it is wonderful to be alive now?... YES or NO
16. Do you often feel downhearted and blue?..... YES or NO
17. Do you feel pretty worthless the way you are now?..... YES or NO
18. Do you worry a lot about the past?..... YES or NO

19. Do you find life very exciting?..... YES or NO

20. Is it hard for you to get started on new projects?..... YES or NO

21. Do you feel full of energy?..... YES or NO

22. Do you feel that your situation is hopeless?.... YES or NO

23. Do you think that most people are better off than you are?..... YES or NO

24. Do you frequently get upset over little things?..... YES or NO

25. Do you frequently feel like crying?..... YES or NO

26. Do you have trouble concentrating?..... YES or NO

27. Do you enjoy getting up in the morning?..... YES or NO

28. Do you prefer to avoid social gatherings?..... YES or NO

29. Is it easy for you to make decisions?..... YES or NO

30. Is your mind as clear as it used to be?..... YES or NO

Appendix E

University of Alberta Faculty of Nursing

INFORMED CONSENT FORM

RESEARCH STUDY: Group Reminiscence Therapy as a Nursing Intervention: An Experimental Study

INVESTIGATOR: Ann Tourangeau, RN, BScN
Faculty of Graduate Studies & Research, Nursing
University of Alberta
Home Telephone: 432-0531

Ann is a Master of Nursing student at the University of Alberta. This study is the material which she will use for her thesis for the degree of Master in Nursing. Her thesis chairman is Dr. Janet Kerr, Professor, Faculty of Nursing, University of Alberta (telephone: 432-6253).

PURPOSE OF THE STUDY: The purpose of this study is to learn about the effectiveness of group reminiscence therapy. More information is needed to support the claim that group reminiscence therapy is an effective nursing intervention for patient care.

RISKS AND BENEFITS: There are no known risks associated with participation in this study. You will be asked to participate in one of three groups - the reminiscence therapy group, a current events discussion group, or a no intervention group. The choice of the group is by random chance. Each group meets once a week for about one hour for a total of 8 weeks. The no intervention group does not meet. If you are asked to participate in the reminiscence therapy group, you will be asked to voluntarily discuss some of your past experiences and memories that you would like to share and to also discuss the experiences and memories of other group members. The nurses who lead the current events discussion group and the reminiscence therapy group have clinical experience in both mental health and gerontological nursing. The nurse who leads the reminiscence therapy group has had experience leading reminiscence therapy groups with patients. Your participation in this study can help nurses gain more information to help them choose interventions or strategies to provide nursing care for patients.

CONSENT: I, _____, consent to participate in the above described research study. I give permission to be in one of the three groups - either the reminiscence therapy group, the current events discussion group, or the group that receives no intervention. I understand that at the end of the study, the results may be published but that my personal identity will be

protected. Only the group leaders and Ann's thesis committee members will have access to information collected. Once the study is completed, all information collected will be destroyed. I understand that I can withdraw from this study at any time with no consequence. I have been given an opportunity to ask the investigator, Ann Tourangeau, any questions concerning this study or my participation in this study. Ann Tourangeau has answered these questions to my satisfaction.

PARTICIPANT SIGNATURE: _____ WITNESS: _____

DATE: _____ INVESTIGATOR: _____